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NOVEMBER
1942

THE CANADIAN NURSE

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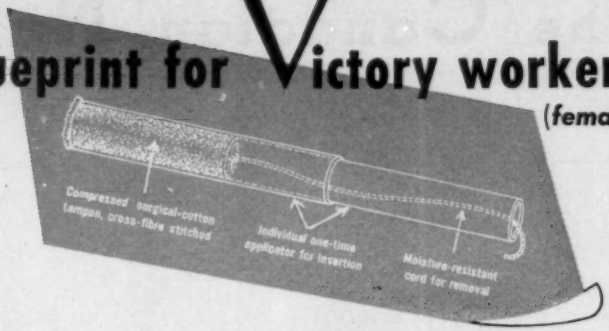
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Reader's Guide

In the leading article, a plea is made for a better understanding of what it means to be **One having authority.** The woman who keeps the wheels of nursing service turning, under conditions which would lay most of us low, does not look for praise. A measure of loyalty and support is the only reward she asks of us.

The therapeutic value of the sulphonamide drugs continues to be demonstrated in all sorts of ways. **Dr. K. J. R. Wightman** and **Lillian Bailey** discuss their use from the standpoint of the physician and the nurse respectively. Dr. Wightman is resident physician at the Toronto General Hospital and Miss Bailey is head nurse in the Medical Ward. These articles were obtained through the committee of staff nurses, organized to get material for publication in the *Journal*, which is under the direction of Miss Mary Macfarland.

The extent to which the community has the right to expect student nurses to carry the nursing load in hospitals is open to question. In the course of some plain talk from Manitoba, and out of her experience as chairman of the legislative committee of the Provincial Association of Registered Nurses, **Elsie J. Wilson** suggests an apt answer.

Traffic in narcotic drugs affects the health and welfare of young Canadians. **Mr. A. M. Shinbane, K. C.**, prosecuting counsel for Manitoba in narcotic matters, gives us an insight into this complex and dangerous situation.

Industrial nursing has expanded enormously as a result of the war and **Dr. F. D. Cruickshank** offers eminently practical advice which should be carefully studied by every nurse engaged in this field. Dr. Cruickshank is the medical officer of the National Steel Car Corporation Ltd., Malton, Ontario.

The integretion of health and community aspects in the basic course is steadily being accomplished. **Margaret Street** in collaboration with **Irene Meyer** discuss this vital subject from many angles. Miss Street is now instructor of nurses at the Misericordia Hospital, Winnipeg, and Miss Meyer has become Mrs. G. F. Harvey. Both authors recently took the course in teaching offered at the McGill School for Graduate Nurses.

Blood donors are more in demand than ever and **Frances Brown** tells us how the work of the blood clinic in Halifax is carried on. Previous to her appointment as technician at the clinic, Miss Brown was engaged in private duty nursing.

Education in personal and public health begins in the schools and should be carried on throughout the school life of every child. **W. V. Godard** makes an illuminating comparison between the health services provided in elementary and secondary schools. Miss Godard is supervisor of the division of public health nursing, Department of Health, St. Catharines, Ontario.

Two graduates of the Mack Training School of St. Catharines General Hospital have contributed to this issue. **Mildred Rundle** gives a vivid picture of how autumn comes to Aklavik and **Ann E. Hutchison** tells us about her student days in the first school of nursing in Canada, fifty years ago.

All progressive schools of nursing offer their students some experience in community nursing. **Eileen Cryderman** describes the educational opportunities offered by the Toronto Health Service, whereby the students in many schools obtain an elementary knowledge of the principles of public health nursing. Miss Cryderman is herself a member of the staff of the Health Service.

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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION
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NOVEMBER 1942

One Having Authority

The problem of providing competent and adequate nursing care for patients in our civilian hospitals has become increasingly difficult during the past few months. The fact that it is being provided at all is due to the unselfish and untiring effort put forth by hundreds of nurses, the country over, who have stayed with their jobs knowing full well that they will never share the glory and applause which are the just reward accorded to more spectacular nursing services.

The almost complete absence of domestic help has further complicated the situation. In many hospitals, graduate and student nurses are sweeping floors, washing dishes, even at a pinch helping in the laundry. Just how long they can be expected to continue to take up the slack is a question which demands more attention than so far has been given to it. Signs are not wanting, however, that relief must be got somehow or other before long, even if it be through the channels of selective service.

While nurses of every rank have made a heroic effort to keep the wheels turning, there is one woman in every hospital who "takes the buffet and cushions the shock". That woman is the superintendent of nurses who, by the very nature of her position, must exercise authority over others. Only those who have themselves faced up to it, can understand how heavy and lonely is the task with which this woman is confronted. Heavy because it carries such a load of responsibility with it. Lonely, because it involves decisions which, for good or ill, she must make for herself. If the decision happens to be right, she seldom gets credit for having made it. If it is wrong, she must take the consequences and keep a stiff upper lip.

Usually these decisions are related to eminently practical problems which call

for immediate action. Here are a few of them. The night supervisor is called up for military service at short notice. Who on earth can be persuaded to take her place? Three student nurses report in one morning with swollen jaws and say that they think they have mumps. It turns out that their diagnosis is correct. Miss Jones should not stay a day longer in surgery because she is due to take her affiliation course in pediatrics. But Dr. Smith is so fussy whenever a new face appears in the operating room, and it is important to keep on the good side of him. Perhaps when he has been on the school of nursing committee a bit longer he will be less difficult to manage. The business manager complains that clerical help simply can't be found, so can a nurse please be spared to relieve on Sundays. The housekeeper says that the nurses will have to look after their own bedrooms and wait on themselves in the dining room. And so it goes, from morning to night. Someone has to reconcile these conflicting demands. Someone has to smooth these ruffled tempers. Someone has to make the right decision and act upon it promptly. Someone having authority.

It has been said that in any organization there is always an unconscious conspiracy against authority. And it is natural enough when one comes to think of it. Most of us would rather have our own way than take orders from someone else, no matter how just and decent she may be. As a rule we do realize that, for the sake of the common good, we ought to adjust ourselves and obey. But few of us really like doing it. If the one having authority happens to be a sensitive and imaginative woman (and she sometimes is) she is perfectly aware of this attitude of mind, and does her best to make allowance for it. If she is frank with herself, she knows that this is the price she must pay for the doubtful privilege of holding a position of power and influence. Sometimes the price seems a little high.

One word more. When the history of nursing education comes to be written the contribution made by the superintendent of nurses should not be forgotten. It is she who wrings one concession after another out of an unwilling board of directors. It is she who keeps the affiliation schedule going even when she doesn't know where to find a night nurse for the woman's medical. In season and out, she fights for shorter hours and better salaries. When things go wrong, she shuts the office door for a minute and hopes the telephone won't ring. Then she goes out and does something about it. Usually the right thing, too. She is one having authority.

— E. J.

Among the Missing

As the *Journal* goes to press, the name of Nursing Sister Agnes W. Wilkie, R.C.N., is listed among the missing after the sinking of the Newfoundland ferry, S. S. Caribou, as a result of enemy action. Miss Wilkie entered the Naval Nursing Service in February of this year and was proceeding to Newfoundland for duty at the Naval Base Hospital. She was a graduate of the School of Nursing of the Winnipeg General Hospital and her family resides in Carman, Manitoba. Although it is considered unlikely that Nursing Sister Wilkie can have survived the disaster, it is known that she made a brave fight for her life and that therefore a spark of hope still remains that she may have been rescued.

Chemotherapy with Sulphonamide Drugs

K. J. R. WIGHTMAN, M. D.

Since 1935 a group of drugs has been placed at our disposal which has had a more far-reaching effect than any other agent we know. These drugs are known as sulphonamides because of similarities in their chemical make-up, and the most important members of the group are sulphanilamide, sulphapyridine, sulphathiazole, and sulphadiazine. The story of their development is a fascinating one, marked by the most careful research on the part of chemists, bacteriologists, clinicians, and pharmacological experts. There is therefore available a greater body of scientific data for our guidance in the use of these drugs than we have for most others. From this we can derive a few relatively simple principles, which, coupled with what we know of the diseases involved, lends a peculiarly rational and logical aspect to this type of treatment — an aspect, however, which does not always find application.

From what has been discovered, it can be said that the drugs work by interfering with the ability of bacteria to make use of their food, thus preventing them from growing, multiplying, and producing toxic substances. Under these circumstances the natural defence mechanisms of the body are able to attack the bacteria successfully, and kill them off. Unfortunately, not all bacteria are susceptible to this action, a fact which makes it necessary for us to determine as soon as possible what bacteria are involved in each patient's disease. This involves the collection of sputum, blood cultures, swabs, etc. before any drug is given, for once the treatment has begun the cultures may not be satisfactory.

Then we find that successful therapy demands that we have a definite measurable amount of the drug present in the place where the bacteria are growing. We are fortunate in being able to measure the concentrations of these drugs in blood, spinal fluid, and so forth, and we make use of frequent blood level estimations in carrying out our treatment. Our aim is to produce a good blood level as soon as possible, maintain it at a high level for a day or so, and then allow it to run along at a lower level until we feel that all remnants of the infection have been eradicated. The drug can then be discontinued without fear of relapse.

To accomplish this, it is necessary to give relatively enormous doses for the first day, with successive decrements until the drug is discontinued. The initial large doses are intended to saturate the whole body with the drug and build up a high level. At this stage there will be tremendous numbers of bacteria present, so it is logical to suppose that more drug will be needed. Later on, blood levels can be maintained by replacing only what is excreted by the kidneys and destroyed in the body, so the doses do not need to be so large. In addition, the numbers of bacteria involved will be decreasing. If clinical improvement occurs, as evidence of this decrease in bacterial numbers, then one can allow the level to fall somewhat. If at any stage along the way we allow the level to fall too low, the infection is apt to light up again. We find that this happens unless frequent doses are given at regular intervals — hence the necessity for giving these drugs every four hours, day and night. Hence also

the necessity for a hard-hearted attitude toward the vomiting patient, for a dose which is vomited within an hour of its administration must be considered a dose missed, so that we must ask them to try again. Nausea and vomiting are sometimes quite severe, and it may tax the resources of nurse and physician alike to persuade the patient to persist in a treatment which must sometimes seem worse than the disease. Sedatives, encouragement, coaxing, and plain bullying may be necessary, but fortunately we have soluble forms of the drug which can be given intravenously if necessary, until vomiting ceases.

During this time certain other factors have to be taken into consideration. Among them is the fluid intake. This has to be limited to prevent the kidneys from excreting too much of the drug, and so lowering the level unduly. On the other hand, one must be sure that the patient gets his full allotment of fluid, or the concentration of the drug in the urine will become too high, and lead to renal damage. The concentration in urine tends to be much higher than in the blood, which is of some importance in treating urinary infections, since the blood level need not be so high. In addition we must keep careful track of the urinary output, being on the watch for reduction of volume or even cessation of urinary secretion. In addition, the urine must be examined periodically throughout the treatment to detect the presence of haematuria, should this develop. An excessive amount of vomiting is also important from the point of view of fluid balance. Other possible reactions to the treatment are the development of fever or rash. Similarly, marked conjunctivitis, cyanosis, involvement of the nerves, acute anaemia, and acute reduction of the white count occasionally occur. The early detection of these complications depends on observation of the patient, and their successful treatment depends, in turn, on their early detection.

In the midst of all these new considerations, it must be emphasized that careful nursing, supportive and symptomatic treatment have still to be carried out, and still constitute a major element in successful therapy of these diseases. Thus we see that a treatment which is relatively simple in principle becomes relatively complex in administration, and that its successful prosecution with a minimum of risk depends on a high degree of co-operation between physician, nursing staff, and laboratory. If these agencies are properly co-ordinated, sulphonamide therapy affords extreme satisfaction — if not, it may be a source of endless worry.

BURSARIES FOR CLINICAL COURSES

The terms by which application can be made for bursaries by nurses who wish to obtain post-graduate study in short term clinical courses are announced in Notes from the National Office.

Nursing Care of Patients undergoing Chemotherapy

LILLIAN BAILEY

Since the introduction of the use of the sulphonamides in the treatment of pneumonia, the nursing care of the disease has not lessened but has been much more satisfactory. The nurse is almost always sure of excellent results as a reward for her efforts but nursing procedures must be carried out just as carefully and as accurately as in the old days. Therefore it would seem best to talk about nursing as we try to carry it out on our pneumonia ward. On admission the patient is made comfortable in bed, and assured that everything will be done for his recovery. The rectal temperature, the pulse and respiration are recorded every four hours during the day and in the evening, from the time of admission to the end of chemotherapy, even though the fever has subsided. A specimen of urine is sent to the laboratory, and cultures of the blood and sputum are required directly after admission. The patient is taught the necessary precautions for the safe disposal of handkerchiefs and sputum.

As explained in Dr. Wightman's preceding article, drug therapy begins at once. Some patients are not disturbed by the drug at all, while others are made very ill and suffer from nausea and vomiting. The patient has to be encouraged to continue the treatment regardless of its severity and it is necessary to explain that this phase of the illness does not last long. Adverse symptoms of chemotherapy must be watched for by the nurse, and reported immediately. The patient may complain of headache, and may develop a rash on the skin. Cyanosis sometimes occurs, and fever may recur due to the drug.

To save energy and give the needed rest is imperative. Restlessness may be controlled by changing the patient's position in bed from Fowler's position to the recumbent position, or vice versa. Massage is also beneficial and mustard pastes may be applied, giving considerable comfort. Sedatives, or sponges, or both, are of real value. The co-operation of the relatives and intimate friends in visiting for only a short time is most desirable and to gain this often requires patience and tact on the part of the nurse. A daily cleansing bath, with special care of the back, is given in addition to sponges. The care of the mouth must be carried out diligently; this means the frequent use of mouth wash and lubrication.

The fluid intake and output are a most important aspect in carrying out the nursing care of the pneumonia patient. The nurse must appreciate the significance of limiting fluids to 1500 c. c. in 24 hours in order to convey to her patient the necessity for co-operation. One could add that it is also necessary to convey this information to the relatives and friends. The fluids most favoured by patients are grapefruit juice and ginger ale. Both are acceptable from the doctor's point of view, or the patients may have any kind of fluid they desire. Fluids should be evenly spaced as to the time of giving and, if possible, 50 c. c. should be given every hour or 100 c. c. every two hours during the day, saving the remaining 300 c. c. for the night. If chipped ice is desired to quench thirst it is considered as part of the fluid intake. All vomitus is measured and the amount is recorded; the amount of fluid thus lost is given to the patient again. All urine is meas-

ured and recorded promptly. The character of the urine as to colour and quantity must be closely observed; a daily morning specimen is sent for analysis. Elimination by bowel is also very important, and is accomplished by giving a cleansing enema every other day.

Nursing care in pneumonia still requires careful observation and attention by the nurse although now, instead of an average twenty-five percent mortality, the rate has been lowered to an average of ten percent. Patients who do not recover fall into three groups: (1) those suffering from other serious diseases, especially cardiac or renal; (2) patients with tremendously virulent infection, such as bacteraemia, or meningitis, who die before treatment has time to have any effect; (3) patients who have been ill for a long time at home untreated.

Autumn Comes in Aklavik

MILDRED RUNDLE

Autumn has already visited Aklavik and is hastily gathering her skirts to visit our southern friends. Perhaps Bruce Hutchison could do it justice, as he does "Canadian Spring." During my seven years in the North I do not remember such colour as we have witnessed this year. The maple-like leaves of the cranberry make the trails a royal pathway. Red, yellow and brown, yellow with red splattered on the edge, green with yellow and red pushing to the centre, each leaf seeming different. The few poplar and willows are already canary yellow while the spruce (the sentinels of the North) remain their staunch, secure dark green. The mountains let the sun and clouds play hide and seek among them and are an inspiration of beauty and amazement. Purple, pink, blue, almost any colour and sometimes snow-capped over night they form a background. The late evening sunset brings added reflections and flaming cloud formations. To complete the picture there are two rainbows. Then there is the Peel River, a branch of the Mackenzie, reflecting all. It seems as though the pictures we have admired but did not quite believe are unfolded before our eyes and one breathes deeply, hoping to become inspired with a mighty goodness.

After dark there are the twinkling stars and the Northern Lights. As if not to be outdone by the beauty of day, I observed a spectacular performance the other night. A circle of light seemed to enclose the cathedral and the hospital, then it became a massive parachute of light. Now it is a serpent and, as it narrows and twists, it consumes a rainbow and the monster's head rears to the south where suddenly the sky seems about to absorb it and a mist is all that is left. But soon another performance starts and so it continues through the night. Sometimes a candle-like flame appears through the trees and we know the picture will soon be complete for the moon is entering her court. Who would not be a missionary in the Arctic?

Last month I made a trip of 150

Eskimo at Richards Island

miles to the Arctic Ocean in our small boat. It is supposed to take four people; we took seven and brought back nineteen passengers. There is no privacy or any kind of convenience in northern travelling. As a man once remarked about a trip to James Bay, "I would not have missed it for a thousand dollars but I don't know if I would do it again for a thousand." En route there was only the country to admire—all was peace and quietness. Leaving the mountains behind, we had the Reindeer Hills as escorts for part of the way. About seventy miles north we stopped at the Reindeer Station to greet the three white families there and give them the latest Aklavik gossip. The trees were already much smaller and gradually we left the hills and growth behind us. Passing Richards Island, I recalled my trip of last summer when I had accompanied the doctor and dentist to the reindeer round-up. Everyone lived in tents and ate in a large tent. They had great difficulty in corraling the reindeer that year but through glasses I observed eighteen hundred being driven over the hills toward us but when within two hundred yards of the fences they milled, went in circles, and stampeded. We were rather surprised on this trip to spy a herd of fifty deer on the mainland. There was one white one and they ran for some distance with the boat. We saw wild swans, geese and ducks. The ocean was rather rough as we raced for Tuktoyaktuk and the waves splashed over the bow of our small craft. The natives would not have travelled in such rough weather we were told. How foolish they must think us — they are always prepared to wait another day.

Almost my first greeting was "there is a sick baby, will you come!" The little Eskimo was having difficulty in breathing and was lying on a mattress on the floor of a tent but everything was clean. I told them I would come again with medicines and from the Hudson Bay first-aid kit I found what I needed. Then with a basin containing the ingredients of a mustard plaster I marched along the beach of the Arctic Ocean, clambering over freight addressed to Coppermine, Cambridge Bay, Bailey Island, Holman, and Reid Island, and all points north. There is only one white family there so there was great rejoicing and gossiping. It was nearly ten years since I had seen the gentleman of the house. There were about one hundred Eskimo people and I shook hands with all during the brief visit. Very few

Eskimo and reindeer fawn

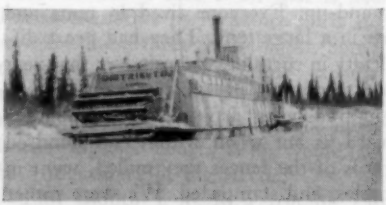
of them winter here. They go further north and we shall not see them until next August. Many of the older Eskimo women still have the tattoo markings on their faces. The return trip was made at top speed as we were so overcrowded. There were children for school, a tuberculosis patient, a member of the Royal Canadian Mounted Police, two carpenters, and a most interesting character who had been in the North for 38 years. We entertained ourselves tying knots when the bear stories ran out.

All Saints Hospital, which is owned and operated by the Diocese of the Arctic of the Church of England in Canada, can accommodate over forty patients and the staff consists of three registered nurses, one acting as nurse-in-charge. Two nurses are supported by the Government, and the third, with the kitchen and laundry matrons, are supported by the Diocese. We try to have native girls as students. One girl stayed three years and now has a tent about 80 miles south and uses her home nursing training to help the Loucheaux people. The building has two storeys with a little cellar for storing goods. There is a large combined dining-room and living-room which is nicely furnished and a residence with four staff bedrooms and a bathroom. In addition to the wards there is a well-equipped room for dentistry — the Diocese sends up a dentist from Toronto each summer — and a large operating-room with an iron-lung, sunlamp, and x-ray. The hospital has its own electric plant for light and power. We have no hot water upstairs but our private patients get a bath every day and ward patients on alternate days. Our patients are tuberculosis, typhoid, pneumonia, obstetrical, tonsillectomy, babies with malnutrition and (worst of all) patients bitten by dogs which are quite equal to any horrors of war.

Aklavik has grown, and now has about 90 white people. We old-timers who live in the past say it is not the same since civilization has come and brought with it tractors, a truck, and planes. Is it worth it? We just smile and do not say much but think of the odd characters we have met and the stories we have heard which will never be printed — the heartaches and disappointments and memories. Yes, I am sure I would do it all over again even if nobody ever does say a "thank you" and I am forgotten in ten years. It has been worth it!

Editor's Note: A few days before Miss Rundle's manuscript arrived the *Journal* was given permission to quote the following excerpts from a letter addressed to Miss Grace Fairley by Mrs. R. J. Renison. Last summer, Bishop and Mrs. Renison made the journey to Aklavik by steamer and Mrs. Renison's comments emphasize the fine work being done at All Saints Hospital:

Two hundred and fifty miles within the Arctic Circle, on the delta of the Mackenzie River, is the Post of Aklavik, only to be reached by paddle-wheel steamer or plane. When our boat dock-



S.S. "Distributor" in winter quarters

ed, after a twenty-six-day trip, flags were flying from every pole, and the entire population was on the bank to greet us. We could see at one end the Roman Catholic Mission, its flag high and, in the centre, the Hudson's Bay Company's buildings. On the other side was the Cathedral of the Church of England, Diocese of the Arctic, with St. George's Cross flying from its tower, and All Saints Hospital where a fine bit of work is being done by three registered nurses. Miss Powell, a graduate of St. Luke's Hospital, New York, is the superintendent; Miss Rundle, a graduate of the Mack Training School of St. Catharines General Hospital, is in charge of x-ray work and also took a course in dentistry before coming to the Northwest Territories; and Miss Brooks, a graduate of the Hamilton General, is supervisor of the operating room. This is one of the brightest, sunniest and most attractive hospitals I have ever been in. Even dying would be a cheerful business. Somehow I felt that one would be quite sure of the future and of loving care to help one over.

To a superficial observer, the hospital has every convenience, but here are a few of the things the staff have to contend with. There is cold running water in the kitchen and laundry only and every bit of water has to be carried upstairs. A small instrument sterilizer operated on the electric current is badly needed for the operating room. I wonder whether an interested group of registered nurses could manage to finance the purchase of one; it would be a great help to other nurses who are doing a fine piece of work.

I passed Post after Post on the great Northern rivers — the Slave and the Mackenzie. High on their banks are the Hudson Bay Posts and the churches and sometimes a hospital. Always there are tents with Indians and howling dogs each tied to its own stake, and a good deal of unspeakable filth. There were two great exceptions — Fort Simpson and Aklavik.

As we were met at the door of All Saints Hospital by Miss Powell in her spotless uniform, and were introduced to her supervisors, I felt that we all owed a great debt to the nursing profession who far away from all that makes life easy are keeping their standard of work and morale high.

"Well, but Busy"

Editor's Note: The following lively excerpts are taken from the annual report of the Nursing Service of the Department of Public Health and Welfare of the Government of Newfoundland:

The Departmental Nursing Service now consists of twelve cottage hospitals, one hospital ship, sixteen public health nursing districts, two nursing stations, and thirty-five nursing districts, including St. John's. The home visits to tuberculous patients numbered a considerable increase over that of last year due, no doubt, to the fact that the nurses are getting to know their patients and contacts, and are giving a more consistent service. It was felt that more prenatal visiting was badly needed, and a maximum co-operation was obtained from the mothers whereby these visits were not coercive but cordial and friendly; they trebled during the year. At the first of the year, the school

nurse became indisposed, and we were faced with 10,000 children in 35 different schools who had always been examined in orderly fashion under the school nurse's supervision. The problem was tackled by the three public health nurses taking charge of the schools in her own district. They were assisted by the assistant organizer of the Junior Red Cross and the public health students. The M.O.H. examined the children, so what looked like an impasse and defeat was turned into victory by interested and alive public health nurses.

Through the co-operation of the Grace Maternity Hospital and the Department of Public Health and Welfare, six outport women, recommended by the nurse or doctor in their districts, have this year been brought to the Grace Hospital for training. This is further augmented by their attendance at our prenatal clinics and post-partum work on the districts, under the nurse's supervision. These women are thus enabled to go back to their homes and give intelligent care to mothers and babies.

It is interesting to note that in all the great marine disasters, the Departmental nurses have played an active part. By their terse monthly reports, one would never gather that they did anything over and above their line of duty, and yet the display of courage, heroism, and devotion to duty has been of the highest order. A few instances pass in review: a tidal wave brought sudden and terrifying devastation to 3700 inhabitants of the southwest coast. The report sent in by the parish priest at that time is that "the nurse, scantily clad, and wearing house slippers (all her other belongings being lost) went from house to house, tending the sick and injured, quelling fears, and restoring confidence. She attempted to travel, but roads were blocked by boulders and wreckage. She secured a horse and rode it until it dropped, then she continued on foot soaked, chilled to the marrow — she continued her work of mercy all night and part of the next day". This nurse's report to headquarters was "Well, but busy."

In a recent disaster, a United States destroyer was pounded to pieces off the rocky east coast with a loss of 189 officers and men. Three nurses were on the scene, then letters arrived from nurses all along that coast where bodies were washed ashore. One letter is quoted in part: "Can you send me a dozen or so death certificates? We had five bodies washed up. The parson is away and I could not get certificates. If we had not had some new lumber for the church repairs, I don't know how we'd have got coffins made. Everyone wondered who would be the first in the new cemetery. I feel sure that the relatives in the United States would be glad to know that their men were decently buried".

A system of modified socialized medicine is one of the features of Newfoundland. Several years ago the only hospitals in the colony were in St. John's. Today there are ten cottage hospitals, at strategic points on the coast, and two more to be built this year will complete the encirclement of the Island. They accommodate twenty-one patients, are modernly equipped with a compact operating theatre, open wards, as well as a private suite, which is often used for observation cases or quarantine.

The present world conflict has brought changes to Newfoundland and her people. We find that because of a great increase in employment, bringing with it a new independence, attendances at the clinic are cut in half; we find the Junior Red Cross members devoting a great deal of time to war work; we find war conditions making even more urgent the need for a larger venereal disease clinic, affording greater privacy. We find public health nurses adding the toxoiding of recruits to their other duties; we find a greater demand for health education, especially in first aid and home nursing, and we find a general unrest bringing many changes in personnel.

There has been no outstanding epidemic in St. John's this year in spite of the increase in population. This is a fact of which the health authorities, both civil and military, may be justly proud, and some credit may be due to the public health nurse who, realizing the importance of a knowledge of health, has made teaching a vital part of her daily program.

SYRETHA SQUIRES
Director, Departmental Nurses

Plain Talk from Manitoba

ELSIE J. WILSON

In 1913 the Registration Act for nurses was passed in Manitoba, the first legislation of its kind in Canada. The standard to be met by students wishing to qualify for registration was not high, but what was important was that for the first time student nurses and nursing education existed as legal entities. We who have followed those women who had the courage to press for this legislation have to a great extent failed to accept the challenge handed to us. True there have been some gains made, but we have on the whole been too fearful of losing the little we have and have hesitated too long in demanding that nursing education receive recognition and financial support from public funds.

Since the original Act was passed in 1913 there have been three amendments — 1920, 1923 and 1929. The Act now provides for reciprocal registration; the applicant for registration must have had preliminary educational standing of grade 10 and have graduated from a hospital having a daily average of 20 patients. The Association now has the authority to enter into an agreement with the University of Manitoba for the conduct of the registration examinations and the curriculum of studies on which these examinations shall be set. It is maintained and rightly, that Universities are the principal agencies maintained by society to conduct professional education and that their function is not only to offer the types of professional education already well established but also to be alert to the educational requirements of new professions and to organize the kinds of professional training as the need becomes manifest. With this ideal of the function of the University in mind, it was hoped that this agreement between our Association and our University would present the needs of the nursing profession in such a way that the responsibility of the University in this field of education would be evident and practical help forthcoming. Undoubtedly it would be, if we could back up our request for help with some thousands of dollars annually. This, I submit, the nursing profession should not be expected to do.

Communities expect to pay for most of their essential services. They do not expect to have their roads and bridges built by student engineers, their animals cared for by student veterinarians, or their farming done by agricultural students but they do expect to have their sick — members of their own families — nursed by student nurses. Furthermore, we are told that if the cheap labour of the student nurse is not available the small country hospital, which is such an essential part of community life, will be forced to close its doors and the sick will be left uncared for. The responsibility for this situation, mark you, is being placed on the nursing profession.

It is impossible to state too strongly how utterly unfair it is to give the general public the idea that we are so concerned with demanding from the student nurse such a high educational standard that we have lost sight of the needs of the sick. As stated by our own Provincial Advisor, in her survey of schools of nursing, the public has criticized the nurse for her lack of education, her poor technical skills and particularly for what they consider are her wrong attitudes. A more ridiculous and unfair situation never before existed in any sphere of ac-

tivity. We are blamed for all the mistakes and blunders of what we are told are ill-prepared nurses, and when we try to spend our own time and money on improving nurses and nursing service, we are confronted with active opposition from sections of the very public we are striving to serve. Nurses by themselves cannot any longer cope with the problem of staffing hospitals and of providing adequate nursing service for the people of Manitoba. We have in the past done more — a great deal more — than our fair share. Each individual community must shoulder, by taxation if need be, the financial responsibility for providing essential nursing services for their sick and the Province must assume the same responsibility for the education of the student nurse as is assumed for other students.

There is no organization that can show a better record of service to the community than can the Manitoba Association of Registered Nurses. If we have been fearful and over-cautious in asking for help from our legislators, we have at least been more than generous with our own time and money, which we have spent freely and cheerfully for the purpose of better preparing nurses to serve community needs. Also, during depression years, when hospitals were graduating hundreds of students (which they needed to run their hospitals cheaply) into a community which could not afford to employ graduate nurses, our Association paid thousands of dollars out of our own funds, to assist these unemployed nurses.

Since we appointed Miss Gertrude Hall as our executive secretary and school of nursing advisor in 1936, the work of the Manitoba Association of Registered Nurses office has increased by leaps and bounds. Her concern for nurses and nursing is so well known that she is inundated with pleas for help from individual nurses and from hospitals. Refresher courses for nurses not actively engaged in nursing, head nurse courses and institutes are only a few of her many projects. We cannot all travel at her pace, but we can all travel in the same direction. We can continue also to give the practical support which is so necessary, and even the least of us can help by being informed about what registration means to nurses and why it is important.

The individual nurse can do nothing by herself to improve her own professional status but, with the strength of an organization behind her, much can and has been done. Registration for nurses has meant that there is, throughout Canada and many other countries, a definite standard on which to base the professional life of the nurse and the education of the student nurse. The organization of nurses has meant improvement in nursing education, in living and working conditions and in shorter working hours. Through registration, and only if registered, can a nurse be assured of employment in other provinces and in the U.S.A. Only if a nurse is registered will she be accepted for service with the Army, Navy or Air Force.

The need for giving publicity to the value of registration was brought home to us very forcibly quite recently. Just before the Legislature prorogued, the Executive Secretary was advised that an amendment was being brought in which would reduce the daily average of patients required under the Act from 20 back to 5. We were told that the amendment would be withdrawn if our Association would promise that for the duration of the war all students applying for registration would be accepted without question. This meant of course that all educational standards would be wiped out just as surely as if the amendment were passed in the House. The

officers and board of managers of the Manitoba Association of Registered Nurses gave this matter very grave consideration, facing squarely all the implications and difficulties involved. They felt they would not be worthy of trust if they meekly submitted without attempting to maintain the standards won for us by others. Having made this decision, plans were hastily made. It was heartening to find so many members of the Legislature willing to listen to us and to help our cause. We are most grateful to those members who gave their interest and to those who spoke on our behalf with the result that literally at the lost moment, the amendment was withdrawn.

The Provisional Council of University Schools and Departments of Nursing

This Council came into being following two meetings of representatives of University Schools held in Montreal in June 1942. These meetings were held at the suggestion of the Canadian Nurses Association. On request Miss E. K. Russell kindly acted as chairman. As announced in the October issue of the *Journal* the organization of the Provisional Council was approved at the meeting of the Executive of the Canadian Nurses Association held on June 23, 1942.

As the name signifies, the Council is of a temporary nature, established for a period of two years "to give further time for wise decision as to the form that the permanent organization shall take."

In order to maintain a close link with the Canadian Nurses Association, the convener of the Committee on Nursing Education is to be a member of this Council, and the president of the Provisional Council is to be a member of the Committee on Nursing Education of the Canadian Nurses Association. It is the intention that these two bodies shall work in close collaboration.

The initial objects of the Provisional Council are stated as follows: to decide upon the form of a permanent association of university schools of nursing; to determine desirable standards for university schools of nursing represented by members of this Council; to strengthen the standards of existing university schools of nursing, and to support the development of future university schools of nursing where desirable conditions exist; to strengthen the relationships between university schools of nursing in Canada and other countries.

The officers of this organization consist of a president, vice-president and secretary-treasurer, and the Executive Committee is to consist of these three officers and the conveners of two standing committees — a Committee on Policy and a Committee on Studies.

Those eligible for membership are the Nurse-Director of each University School of Nursing and all full-time nurse members of the staffs of these Schools. Membership is to be on an individual basis with an annual fee of two dollars.

Members of the Provisional Council look forward to meeting at least once a year. In the interim between meetings the business of the Council will be carried on by the Executive Committee. The following were elected to office for

the next two-year period: president, Kathleen W. Ellis; vice-president, the Reverend Mother Allaire; secretary-treasurer, Mary S. Mathewson.

The formation of this Provisional Council marks another step and one that it is hoped will be significant in the history of the nursing profession in Canada. It is the intention that within the next two years the Council will demonstrate its usefulness by assisting University Schools to make an increasingly valuable contribution to nursing service in Canada.

KATHLEEN W. ELLIS
Emergency Nursing Adviser
Canadian Nurses Association

Hospital Adventures of a V.A.D.

I feel I have won my spurs and, to prove it, I have at hand a card signed by the charitable and patient supervisors who, for their sins, were obliged to put up with me while I spread confusion in their wards amongst patients, ward maids, and student nurses. Any one may be a student nurse, and it is very easy to be a graduate. The easiest job I know is to be a supervisor and the laziest position in the hospital is that of superintendent of nursing and of the training school. But let me tell you that it is no easy job to be a V.A.D. First, one must follow courses on home nursing and first aid and be examined by the chief surgeon who is keen on thirteen pressure points and is very serious about the exact mathematical fold of a bandage on the leg or arm. His special pet and my pet abomination is a spica — the shoulder being his joy. He does not make our troubles any less by having a small boy as a patient who takes his position with a facetious grin and a cynical sneer at our ignorance and incompetence.

While jumping these two hurdles, we were obliged to have weekly drill and courses on bandaging and gas poisoning, with a refresher which is a yearly occurrence — followed by an examination to keep from getting stale. But this is not all. Before we could enter the sacred portals of the Hospital, we were directed to follow an intensive course given by a most efficient, patient and gracious graduate to whom we were greatly indebted. On entering the classroom, we were instructed how to make beds. This is my greatest accomplishment — closed beds, open beds, ambulance beds, ether beds, day beds and convalescent beds, are all taken in our stride. Trays and baskets are also added to baffle one and make life more complicated Baths were given to "Judy" and her hair was washed and combed and next we were taken to the utility room and taught with what ease and grace one could manipulate bedpans and urinals. We were then shown a most beautiful sterilizer and taught how to use it — but alas! I was soon to find out that all sterilizers were not equally harmless. A sore and bandaged finger was evidence that these innocent pieces of equipment may pinch or fall down and hit one. At last the great day came when we were examined. When the superintendent asked me "What would you put in an ether bed?" All I could say was "a patient" and was surprised when she asked "what else"? The examinations over, the next step was our being posted to the wards and we went forth with all the courage we could muster. All the nurses were so kind, patient and understanding.

Each and every one from the superintendent to the newest "probie" extended a welcoming hand to us. To the superintendent is due all the credit for she had to re-arrange her classes to make room for us and then change all the hours of the nurses on the wards to fit us in. We hope that our work and behaviour while in the hospital will have broken down any prejudice that might have existed previous to our coming.

— MRS. W. DELANEY.

The Illegal Traffic in Narcotic Drugs

A. M. Shinbane, K.C.

I am very glad indeed to note the interest of nurses in the grave and far-reaching problem of the illegal traffic in narcotic drugs which, in Great Britain, are more accurately referred to as dangerous drugs. Addiction produces an unbelievably swift degeneration of the normal elements of character so that fundamental decencies are rapidly weakened and ultimately destroyed. It is regrettable that in Winnipeg, heroin, because of this very potency has become the principal drug of addiction.

Originally opium was eaten rather than smoked and it was not till Portuguese merchants in the seventeenth century introduced tobacco smoking into China that the real impetus was given to opium smoking. We know of course that backward China immediately endeavoured to suppress its use, but that the British East India Company, having taken over the Indian monopoly from the Great Mogul in 1757, and having assumed control sixteen years later of the trade with China, did not take kindly to the edict of the Chinese Emperor. Just before the turn of the eighteenth century the Emperor forbade its importation but in the all-powerful interests of the Open Door, two wars (which an unappreciative posterity has designated as the Opium Wars) were waged to ensure the rights of the Company, and in 1858 the unrestricted opium trade was legalized by solemn treaty. Opium became big business and the Indian monopoly alone was worth $20,000,000 a year to its owners. Even today in Oriental countries there are governmental monopolies — by no means in exclusively Oriental hands — which sell prepared opium to the natives but prohibit its sale to Europeans. Japan, with its usual initiative has taken a leaf from the Western book and now in Manchukuo — Chinese Manchuria to you and me — has an opium monopoly, which sells freely to the Chinese (but not at all to the Japanese). This monopoly is regarded as so important that to ensure its proper development it is directed by the Ministry of Finance which floats bond issues with opium revenue as backing. The Chinese government is endeavouring desperately to throttle the traffic, although in large measure its efforts are being offset by the well-known "pacification" methods of the Japanese Army.

Thanks to alert and intelligent direction, the Narcotic Division of the Department of National Health has been making very real and substantial progress in its never-ceasing battle against the evil of illegal drugs. Ten years ago it was conservatively estimated that there were no less than eight thousand addicts in Canada. Today it is safe to say that the number has been reduced by at least one-half.

It must be emphasized that successful treatment of drug addiction necessitates complete isolation and institutional care of the addict as well as constant supervision. Ambulatory treatment and free "clinics" are worse than useless, in fact they aggravate and increase rather than abate the evil. We provide sanitaria for the treatment of tuberculosis; we have quarantine and isolation hospitals for contagious diseases but we have as yet — in this Province at least — no statute to commit a known addict for treatment and no institution in which to treat him.

The problem of drug addiction in Europe and America began to attract the attention of specialists in the field as early as the middle of the nineteenth century and it appears today to be an amazing reflection upon the short-sightedness of governments and medical authorities that not until thirty years ago was any effort made, by legislation at least, to curb the abuse of these drugs or to interfere with the traffic in them. To Canada belongs the distinction — excepting always benighted China — of introducing the first legislation in modern times aimed to curb the illegitimate traffic in narcotic drugs. In 1892 Canada imported no less than 150,000 pounds of opium. In 1908, following upon anti-Oriental riots in the cities of Vancouver, Victoria and New Westminster, the Dominion Government was presented with huge bills for damages by the aggrieved owners of some seven factories in Vancouver, Victoria and New Westminster, who, without any hindrance, had been engaged in manufacturing smoking opium from the crude importation and in support of their claims these owners submitted verified statements showing their annual receipts to exceed $600,000. The result was that the first Dominion Opium Act which made it an offence to manufacture or deal in opium other than for normal medical purposes. The further result was that instead of importing 150,000 pounds as formerly there was imported lawfully into Canada last year for the needs of a population double that of those years, only 458 pounds, a decrease on a population basis of over 33000%. Once the attention of the Canadian authorities was directed to the problem it quickly became manifest how the traffic not only in opium, but in morphine, cocaine and heroin had spread like a blight over the Dominion and in 1911 Parliament extended the scope of the Act to restrict the sale and distribution of the various derivatives of opium and cocaine. To keep pace with and checkmate the ingenuity of the illicit traffic the Opium and Narcotic Drug Act has been amended and extended every few years. Today our legislation is a model for many other countries.

In the United States the legislative problem is accentuated by states' rights which make Congress impotent to enact criminal legislation and remedial measures have had to be disguised as revenue laws. It was not until 1914 that the Harrison Narcotic Act was passed, dressed up as a Revenue Act, which was aimed to wipe out the illicit traffic by taxing it out of existence. It was not until 1922 that wider legislation — corresponding in effect in some degree at least to our own law — the Jones-Miller Act, was passed to fulfil United States obligations under the Hague Convention.

In the first decade of the twentieth century the problem had become recognized as international and world-wide in scope. The first International Conference (if we disregard a meeting at Shanghai a few years previously) was held at the Hague in 1911 (it will be noted three years *after* the Canadian Act) and a second one early in 1912. Forty-four of the forty-six countries attending (Germany and Austria being the exceptions) undertook to ratify the agreement then made that the manufacture, sale, and use of these drugs should be confined to legitimate purposes. But before the good intentions of the conference could be translated into effective law the first Great German War broke out; the emphasis was shifted from the preservation to the destruction

of human life and nothing more was done until the conclusion of peace.

The Treaty of Versailles was not all bad as propagandists would have us believe. Among its provisions was one whereby the International Opium Convention was incorporated in the treaty and brought into force. Similar provisions were incorporated in the treaties with Austria and Bulgaria, and control of the traffic in dangerous drugs was entrusted to the League of Nations which in 1920 set up an advisory committee of experts. Colonel C. H. L. Sharman, C.M.G., Chief of the Narcotic Division of Canada's Department of National Health, has for many years been one of the outstanding members of this committee and no inconsiderable part of the advance that has been made in recent years to control and curb the world traffic in illicit drugs has been due to his expert knowledge and courage.

In a world beset by political alarms and urgencies it has been inevitable that attention should have been focused on the political functioning of the League of Nations. Little has been heard of the magnificent results it has accomplished for the protection of women and children and almost nothing of what it has done for the alleviation of the cancerous trade in dangerous drugs. It is only in mathematics that two and two always make four. Two countries acting individually sometimes do not evince the moral rectitude of two countries acting publicly and in concert. Open covenants openly arrived at have proved very effective indeed in shaming some countries into setting their social house in order. For a good many years two large countries sometimes covertly, sometimes quite openly, pandered to drug smugglers and catered to the desires of the large drug rings. But by successive conferences and determination an international agreement was recently achieved at Geneva which provides not only for uniform limitation, regulation, and control by practically every country in the world but which vests a large measure of supervision and administration in the League office, and which now has finally provided for world-wide extradition and punishment of offenders against the drug laws. On the whole it may be said, with some confidence, that whatever may be the retrogressions in other spheres of international activity an aroused and informed world opinion is bringing measurably closer the day when the black plague of narcotic addiction may be controlled as successfully as the white plague of tuberculosis is today.

On the home front we must never lose sight of the fact that while the Narcotic Division is rendering invaluable and immeasurable service in curbing the illegal traffic in narcotic drugs, the huge profits obtainable will always attract the human jackals, frequently non-addicts themselves, who prey upon vice and weakness so long as the appetite for drugs remains. Crime and criminal associations are intimately related to this traffic and its participants, whether dealers or consumers. Four remedies are available: apprehension of and long-term sentences for traffickers; co-operation by members of the medical and nursing professions to ensure that drugs are not prescribed or administered except for absolutely essential medicinal purposes; compulsory isolation, supervision, and institutional care of the drug addict; and finally the social and environmental rehabilitation of the cured addict to safeguard him from the relapse that inevitably follows upon the return to his old environment.

The Industrial Nurse

F. D. Cruickshank, M. B.

Until the last few years, industry has not recognized, except in rare instances, the value of the industrial nurse, but the exigencies of war work has brought her to the fore. It has apparently been difficult for employers of labour to appreciate that industrial ill-health falls within the scope of the trained nurse and that she is an important link in the chain of events that leads up to prevention of industrial absenteeism. The working time lost by employees in our war industries should be of serious concern to every industrialist, as collectively it amounts to a considerable figure and, in the case of skilled workers, especially those on team work, leads to dislocation of factory processes, undue burden on others, and a consequent falling-off in out-put.

Each industry may have its own peculiar problems of health, but there are certain broad principles which can be taken as a basis for the introduction of measures relating to hygiene in the factory. It is here that the nurse will take her place beside the doctor in the well-organized medical department in caring for the physical and mental needs of the individual at work. The modern employer is beginning to recognize the economic value of a well-organized medical department, and labour is soon going to demand it. The duty then of the doctor and nurse is to do all in their power to keep the individual worker in good health, and on the job.

It has been said that the successful industrial doctor must know every phase and operation of the industry he serves, and to no less extent this applies to the factory nurse. Transplanting a graduate from hospital bed-side to factory is not as simple as it appears. The nurse must become acclimatized to her new environment, and develop a reasonable knowledge of her industry's requirements. To acquire this knowledge, frequent and thorough tours of the factory with the doctor are important, and the occasional inspection with a representative of the Department of Industrial Hygiene is always most helpful. The nurse, on her inspection of the plant, which in most large industries is advisable at least once a week, may pay particular attention to the work engaged in by the female employee. Is her dress suitable for the job she is on? Loose clothing that might become entangled in moving parts of her machine are a definite hazard. A lock of hair protruding from beneath her head-dress is dangerous and, just the other day, I heard of a girl who lost a considerable quantity of her hair when it became caught in a machine. Fortunately, in this case, her scalp was not seriously injured, but one could imagine a partial scalping by such an accident! If there is a heat-treating or plating department, the nurse will want to know about exposure to dangerous gases and chemicals such as chromic acid and cyanide. In the paint shop, are lead and chrome compounds being used, and is there exposure here? Are suitable masks available to the sprayers, and are they careless about their use? Are the welders amply protected by goggles, and do the girls appear more anaemic in this or that department? Observations such as these are important, and necessary, if the nurse is to have an appreciation of the individuals who present themselves at the dispensary later on.

The psychological effect of the nurse in going through the plant is not always recognized, but nevertheless it has a definite value. The tidy, uniformed nurse makes an impression on the worker, and her interest in their individual job brings them closer together. Workers are more likely to consult this alert type of nurse than the one who sits and waits behind her desk for something to happen. Undoubtedly the nurse who knows the factory and its workings will be more appreciative of the hazards that confront the employee, and consequently better able to efficiently deal with their problems.

A nurse, to measure up to this type of job, must be possessed of a spirit of service, and not afraid of hard work. She will find in industry a greater opportunity to exercise her talents than in any other branch of nursing, and also that this work gives her a chance to emphasize the preventive rather than the curative side of nursing. An active interest in public health work is desirable, as the practical application of preventive medicine in collaboration with the doctor is proving to be one of the most fascinating problems in the whole field of industrial hygiene. The nurse's recognition of a health hazard, often by chance, may lead to extensive investigations being carried out by industry, the medical profession, and the Department of Industrial Hygiene. The co-operation of the doctor and nurse with the factory engineer is important in preventing and solving factory health hazards.

In the dispensary, the nurse has an all-important place, inasmuch as she is, in the majority of cases, the first one to see the workman who is ill, whether this illness is caused by his occupation, or otherwise. With her rests the responsibility of bringing to the notice and attention of the doctor any illness or accident that she considers beyond her sphere. This is so important. If the nurse fumbles the case it is often neglected, and too often with serious results. The nurse must never minimize, no matter how trivial the case may be. Efficiency in the nurse's work is not dependent on the number of major cases that come to the dispensary—as they would receive adequate treatment anyhow—but on the minor ones, which often, if not correctly treated, may become major ones.

There are distinct types of cases coming to the hospital. The accident cases will be of every degree and description and must be correctly allocated—those requiring the doctor's attention, and those minor enough to be dressed and put back to work at once. It is often difficult for the nurse to make this allocation but she must always give herself the benefit of the doubt, and will likely retain her job longer. A nurse must not attempt to practice medicine. She is not licensed for this, and too often this is not observed. It is not wise or legal for her to use the eye-spud, the scalpel, or to administer on her own initiative serums or hypodermics that are clearly labelled "to be used only under a physician's direction". Employers who encourage such practice should be politely told that it is beyond the nurse's sphere. Likewise the careful nurse does not attempt to diagnose. This will often prove embarrassing to herself as well as to the doctor, and may be disastrous to the worker. Some employers provide cold serum to be administered by the nurse without medical supervision. This is a dangerous practice and is doing more than anything to give cold serum a black eye.

If the factory nurse is to retain the confidence of the female employee, she must be careful not to play favourites. Associating with the girls from the office, in the cafeteria and in the grounds

at lunch hour, is a mistake. Also calling in the office worker ahead of the factory girl, from the waiting room will be resented, and soon destroys the nurse's value in the plant. The nurse can do some fine diplomatic work by lunching occasionally with the girls from the factory, and also by attending some of their social functions. This promotes goodwill, and the nurse is soon looked on as a friend. It is well to remember that the gulf between factory and office is greater with the girls than with the men, and it is well for the nurse to recognize that today many of the girls who are welding or riveting in the factory have social and educational background as good as the girl who takes the notes from the manager. In fact, today, with the spirit of national war effort and sacrifice paramount, you will find in our factories many girls with excellent education and high social standing. The nurse must be one of the first to recognize this, and pay deference to it, if she is going to retain her hold on the confidence of the employees.

The nurse's personal appearance is of major importance. Just because she is working in a factory, and dealing often with grimy individuals, is no reason why she should wear a spotted uniform and have untidy hair. Personal appearance counts for as much in the factory hospital as it does in the private pavilion.

So much for ethics and professional conduct. On the practical and preventive side of the industrial nurse's work her first consideration is the initial treatment of accident cases. Rigid adherence on the part of the nurse to the surgical rules laid down by the doctor is most important. Eternal vigilance is the price of safety, and this is a good rule that the nurse must follow at all times, and the careful cleansing and sterilization by the application of some suitable antiseptic to the most trivial scratch may prevent serious infection and subsequent loss of time. The personnel of every factory hospital have seen far more trouble arise from a pin-prick than from an amputation. It is well for the nurse to learn if there is a type of infection peculiar to her own industry. For instance in the aircraft industry we have aluminium alloys that prolong the healing of cuts. Very small particles of Dural in a cut may prevent it healing for weeks. We have overcome this to a large extent by education and the use of alcohol dressings. Employees working with aluminium compounds are repeatedly warned to come to the dispensary with every scratch. The nurse washes the cut thoroughly with green soap and water, and applies an alcohol dressing. This, again is one place where the nurse must be familiar with her own industry.

The man who comes into the hospital complaining of stomach-ache, and asks for a seidlitz, or stomach powder, cannot always be dismissed lightly. The wise nurse will often recognize that he may actually be suffering from lead poisoning. This is a case for the factory doctor, for if the employee is allowed to go home and call the family physician, who is unfamiliar with his exposure to lead, he may come to an unnecessary surgical operation. This has happened on more than one occasion. Chrome, in paints, may cause an intense itchy rash as will amyl acetate which is used sometimes as a substitute for butyl acetate in certain paints.

Cadmium is a metal that is used extensively in certain industries in electroplating and soldering. If the industry uses this metal the nurse should know it. The man who comes in with a tightness in his chest and asks for cough medicine may be suffering from cadmium poisoning, and require urgent medical at-

tention if his life is to be saved. These cases develop a pulmonary oedema.

A workman may come in with many small burns on his arms. They may look quite simple, and he may be apologetic about coming to the dispensary for such a trivial thing — but in a few minutes, he faints, and then if the nurse is familiar with the plant, she will want to find out if they are cyanide burns. Cyanide is used for the hardening of machine tools, and neglected burns from it are sometimes fatal, unless the chemical is all removed. This is done by the doctor forcibly scraping the burns with a sharp scalpel, and liberally washing with plain water. A cyanide burn the size of a quarter may be fatal. Chrome burns are also serious but not so fatal.

Another workman may comes in with a nose-bleed, quite a common thing in everyday life, but if he works in the heat-treating department or the paint shop, he may have been exposed to chromic acid or zinc chromate, and investigation of his nose-bleed may reveal a perforating ulcer of the nasal septum. This workman must be removed at once from this hazard, and have prolonged treatment if a permanent disability is to be prevented. An intelligent nurse will look for cases like this as, with men in this department, familiarity breeds contempt, and they are inclined to minimize their trouble until too late.

A girl who comes in for an aspirin tablet may reveal a pair of sore-looking hands. An observant nurse may realize something is amiss before the patient. If this girl operates a lathe, she is probably suffering from irritating cutting oils or compounds — an occupational dermatitis. An alert nurse may save this worker a great deal of discomfort, and prevent another lost-time accident by sending this case to the doctor. It is interesting to note that blondes are more susceptible to occupational dermatitis than brunettes, as are individuals with athlete's foot, seborrhoea, anemia and rheumatism. Employees on machines using cutting oils, who wash frequently, will do much to avoid skin irritation. This is something for the nurse to urge repeatedly. She can also see that the soap used in the washrooms is rather mild, as many strong soaps only increase the irritation. The nurse can also advise against the use of petroleum benzine, turpentine, and other solvents that workmen are apt to clean their hands with, as often the dermatitis they have is the result of the methods they use for cleaning their hands, rather than the oils and compounds.

A nurse may notice that the girls in the welding department appear more anaemic than those in another department, and she could bring this to the attention of the doctor, who would investigate it. In this particular department, if there is faulty ventilation, the fumes from the welding compounds may cause a progressive anaemia. In a case like this, the company would increase the efficiency of the worker by improving the ventilation, and the providing of iron tonics.

Every factory employing large numbers of girls will find many coming to the dispensary daily for cough medicines. It is a well recognized fact that the bronchial membranes in the female are more easily irritated by dust and gases, than in the male. A certain number of these girls will worry about the possibility of tuberculosis, and this is one place where the nurse can lend a helping hand, as their fears must be either dissipated or confirmed. If they will not go to their family physician, they may be directed to some clinic like the Gage Institute, for investigation.

The factory nurse may be of help by giving simple advice on diet. Girls who appear under-nourished and are con-

tinually coming to the hospital for headache tablets may be advised on their food, and possibly the correction of constipation. In our industry, we find more girls complaining of faintness and sick stomach in the morning than men, and in many of these cases they have come to work without breakfast or, at best, without an adequate meal. Those suffering from a sluggish liver and faulty elimination feel their worst in the morning, and this no doubt accounts for the high incidence of sickness amongst the girls in the early hours of work.

Companies who employ a nurse to follow up absentees are providing a useful service, as many employees will remain at home for a day or two without medical attention. A suggestion from the visiting nurse that they see their doctors is often heeded, and they will be back to work that much sooner. In the case of key men, this is, in these days, an important thing.

The nurse must be careful not to suggest this or that doctor, as the individual is still entitled to his choice of physician; this is something that is too often forgotten. Accidents and occupational diseases are, of course, undoubtedly better handled by the factory doctor, who is, in a sense, a specialist in this particular branch of work. Especially in the occupational diseases, his familiarity with the industry and the materials used may be the important thing in treatment. Just as we mentioned in cadmium and lead poisoning, the family doctor, no matter how brilliant, might be at a decided disadvantage in treating these cases.

Besides the specific cases mentioned, there are a variety of individual troubles being presented to the nurse daily, many of them nervous and mental. A man may be coming repeatedly to the dispensary complaining of this and that, and saying he "feels all-in", and although he has no apparent disease, he may be full of symptoms. The nurse, by the confidence she radiates, may be the first one to find out from him that he is in trouble at home. The nurse will run across many cases like this, and by helping, even in a small way, the person in trouble, she may be indirectly helping production in the plant, as well as bringing happiness to the individual.

Industrial psychology is a subject worthy of more attention, because often sickness absence in industry may be due to other than physical causes. The worker may be in the wrong job or under the wrong boss. No one, probably, will have a better opportunity than the nurse to measure the mental make-up of those with whom she comes in contact.

Aprons and Bare Legs

The epidemic of bare legs is spreading. The London County Hospitals, Guy's Hospital, Manchester Corporation Hospitals, as well as the hospitals of the Lancashire Mental Hospitals Board, allow members of the nursing staff to leave off their stockings. Evidently the country feels that a uniform is not complete without stockings for all members of the women's Services keep their legs covered. The wearing of black non-porous shoes next to the skin may cause blisters and sores which may affect the health of the nurse and therefore the welfare of the patient. If the country can still afford to give stockings to its other uniformed services, should the nurse not have the same privilege?

— *Nursing Times*

Notes From the National Office

Contributed by JEAN S. WILSON,
Executive Secretary, The Canadian Nurses Association

Health Notes by Radio

The Canadian Nurses Association appreciates very much that in National Health Radio Notes issued during the month of October, the Publicity and Health Education Division of the Department of Pensions and National Health arranged to have a "Note" on Nursing announced every second day. Each "Note" has an appeal to some specific aspect of nursing service. The Publicity and Health Education Division of the Department of Pensions and National Health plans to release similar announcements during ensuing months.

This further evidence of the Department of Pensions and National Health to co-operate with the Canadian Nurses Association is most gratefully acknowledged. The Association is already indebted to this Federal Department for a grant of $115,000.00 for the fiscal year 1942-43 (see *The Canadian Nurse*, September issue, page 607.)

The National Health Radio Notes are being announced daily by 27 private stations; 21 C.B.C. supplementary stations; 26 network stations, and by 10 basic stations of the C.B.C., a total of 84 stations.

Post-Graduate Clinical Courses

The Committee appointed by the Canadian Nurses Association to award bursaries to candidates for post-graduate clinical courses wishes to announce that applications for these courses must be sent to National Office before December 31, 1942. A candidate for this type of bursary should have at least six months' experience following graduation in the field of nursing in which she wishes to take a post-graduate course. A candidate should hold a complete high school provincial certificate or matriculation standing (or equivalent), be a graduate of an approved school of nursing, and a member in good standing of a provincial association of registered nurses by which a nurse becomes a member of the Canadian Nurses Association. An evaluation of an applicant's personality, interests and potentialities will be obtained. Each candidate to receive a bursary will be under contract for a year's service in civilian nursing in Canada following completion of her course. Preference will be given to applicants who select a course in which university study is given concurrently with clinical experience.

The maximum amount of this type of bursary will be two hundred and fifty dollars depending on the amount required for travelling expenses.

Also a limited number of applicants will be considered who, having secured advanced preparation in nursing by a year or more at a University, may wish to broaden that experience through observation in some other large centre.

Bursaries can be awarded for clinical courses in Canada only.

Application forms may be secured from the provincial office of each association of registered nurses.

A Correction

A Brief on Nursing Service in relation to Health Insurance as submitted by the Canadian Nurses Association to the Federal Authorities early in June 1942, was published in the September issue of the *Journal*, pages 709-711.

It is regretted that in copy of the Brief sent to the Editor of the *Journal*, paragraph three, under the section "Health Insurance Councils" was not revised to coincide with the final revision of the Brief. The concluding sentence of paragraph three should be: "It is further recommended that, to effectually coordinate the work, representatives of the different fields of nursing should be rotated on these councils and on regional advisory committees."

Canadian Women in the War Effort

Among the series of Canadian War Pamphlets issued by The Macmillan Company of Canada Limited, is one "Canadian Women in the War Effort" by Miss Charlotte Whitton, which is a compilation of information about every organized group of women in Canada which is making a planned war effort.

Organizations of nurses may secure this pamphlet for distribution to members on the following terms: less than 99 copies, 50c each, less 33-1/3%; 499 or less at 50c each, less 33-1/3% plus 5%; 500 upwards, 40%. Orders for copies should be sent to The Macmillan Company of Canada Limited, St. Martin's House, 70 Bond Street, Toronto.

Bursaries Awarded

In the September issue of the *Journal*, the President of the Canadian Nurses Association announced the allotment and purposes of a grant of $115,000.00 as received from the Federal Government for the fiscal year 1942-43.

One allotment of the grant, twenty-five thousand dollars, is "to provide scholarships for graduate nurses who are deemed by the Canadian Nurses Association to be promising material for education as teachers, supervisors and administrators".

The Committee appointed to select promising candidates for bursaries (scholarships) from applications received met on August 29 when, before considering a large number of applications, the following policies for the Committee's guidance were adopted:

1. That funds for bursaries be used for study in Canada only (a federal government ruling).
2. That approximately $2500.00 be earmarked for French-speaking applicants.
3. That a contract be required from recipients of bursaries and that each recipient be asked to postpone military service until the contract is fulfilled.
4. That applicants who had enrolled for courses after the announcement of the grant be given first consideration.
5. That the Montreal members of the Committee be authorized to deal with any further applications.

Four meetings of the Committee were held between August 29 and September 17. A total of 112 applications were received. Forty-five applicants were awarded bursaries. The Committee realized that all successful candidates should be enrolled before September 30, therefore every effort was made to deal speedily with each applicant. Unfortu-

Province	Teaching & Supervision		Administration		Total Amounts
	Schools of Nursing	Public Health	Schools of Nursing	Public Health	
Alberta	3	—	1	—	$1,965.00
British Columbia	3	—	—	1	1,600.00
Manitoba	4	3	—	—	2,765.00
New Brunswick	1	2	—	—	1,330.00
Nova Scotia	1	2	—	—	1,400.00
Ontario	1	4	1	1	2,650.00
Prince Edward Island	—	1	—	—	265.00
Quebec	— (French)	7	(French)	2	2,525.00
	— (English)	1	—	—	500.00
Saskatchewan	5	1	—	—	3,000.00
					$18,000.00

nately aproximately thirty percent of applications were not in complete form —in most instances the required three letters of reference did not arrive.

The applications by French-speaking nurses were considered by their representatives on the Committee.

The allocation of bursaries according to Province showing the number of awards for a year's study at a University Department or School of Nursing is indicated in the above table.

British Nurses Relief Fund

Contributions to the British Nurses Relief Fund have been received from:

Alberta:

University of Alberta Hospital, Edmonton	$50.05
Royal Alexandra Hospital staff, Edmonton	25.75
Royal Alexandra Student Body, Edmonton	10.00
Misericordia Hospital, Calgary	13.50
Calgary General Hospital	40.00
Student nurses, Holy Cross Hospital, Calgary	31.00
A. A., Lamont Hospital	13.35
Stettler Graduate Nurses' Group	9.00
Drumheller District No. 5	65.00
Calgary District No. 3	20.00
Country hospitals	46.00
Individual donations	76.35

Nova Scotia:

Halifax Branch	11.75
Pictou Co. Branch	3.00
Valley Branch	16.75
Colchester Co. Branch	15.00
Leneburg Co. Branch	5.00

Ontario:

District 1:	
A. A., Memorial Hospital, St. Thomas	11.25
District 4:	
Graduating class, Hamilton General Hospital	100.00
District 5:	
A. A., Women's College Hospital, Toronto	50.00
A. A., Toronto General Hospital	125.00
Matron and Nursing Sisters:	
Camp Borden Military Hospital	35.00
Chorley Park Military Hospital, Toronto	25.00
District 7:	
Nursing staff, Ontario Hospital, Kingston	142.00
District 9:	
Sault Ste. Marie nurses	28.00
Kirkland Lake nurses	10.50

Annual Meeting in New Brunswick

The annual meeting of the New Brunswick Association of Registered Nurses was held recently in St. Stephen, with 107 members in attendance. In her presidential address, Sister Kerr spoke of the work of the Emergency Nursing Adviser and outlined the program formulated by the joint meeting of representatives of our Canadian Universities and the Executive of the Canadian Nurses Association. The report of the secretary was given by Miss Law who stated that the membership of the Association is now 914. The report of the treasurer, also given by Miss Law, showed the financial affairs of the Association to be in good condition. The Legislation Committee report was presented by Miss B. L. Gregory.

Miss Margaret Pringle presented her report as Emergency Nursing Adviser and much discussion followed. Miss Alma Law reported on the general meeting of the Canadian Nurses Association. Miss Marion Myers, convener, Hospital and School of Nursing Section, presented her report and suggested that the chapters, committees and groups undertake, as part of their year's activity, a comprehensive study of the reports of the work of the Canadian Nurses Association appearing in the September number of *The Canadian Nurse*.

Miss Helen Cahill, convener of *The Canadian Nurse* committee, reported an increase of twenty-three subscriptions over last year. Miss Clara Boyd, convener of the Committee on Instruction, reported a meeting held to consider an outline of study relating to uniformity in our provincial R.N. examinations. The following recommendations were submitted: that two and one-half days, instead of two days be given applicants to write their examinations; that the pass mark be changed to 60 instead of 50, and that the aggregate marks be 540 with not less than 45 on any subject. Miss Ada Burns, convener, Public Health Section, reported three new appointments made by the Government in the field of public health nursing. Recommendations from the Public Health Section, Canadian Nurses Association, were read. Miss Myrtle Kay, convener, General Nursing Section, brought in a recommendation that eight-hour duty be adopted and the following schedule of fees be approved: eight-hour duty, $4.00; twelve-hour duty, $5.00; twenty-hour duty, $6.00.

Miss A. J. MacMaster, convener, Scholarship Award Committee, reported that a scholarship of $250 was awarded Miss Louise Bartsch who is taking a course in administration at the School for Graduate Nurses, McGill University. Mrs. G. E. van Dorsser, chairman, Enrolment of Nurses Committee, spoke of the importance of continuing enrolment in case of disaster. Miss Ada Burns, convener, History of Nursing Committee, reported continued efforts to collect all historical items of interest in our province. Miss Mabel McMullen, convener, committee to study eight-hour duty, presented her report and, though it was felt that eight-hour duty would be ideal, the time is inopportune and it remains an objective for the future. A round table conference on current nursing events, conducted by Miss Marion Myers, proved interesting and instructive. The reports on local chapters showed a very active year.

The following officers and conveners were elected: President, Rev. Sister Kerr; first vice-president, Miss Lois Smith; second vice-president, Miss Reta Follis; hon.-secretary, Miss Mabel McMullen; Conveners of Committees: advisory committee of schools of nursing, Miss A. F. Law; legislation committee, Miss Dorothy Parsons; *The Canadian Nurse*, Miss Nellie Wallace; Public Health Section, Miss Muriel Hunter; General Nursing Section, Miss Mary Harding; education and instruction, Miss Marion Myers; Representatives of Chapters and Districts: Miss A. J. MacMaster, Moncton; Rev. Sister Saint Stanislaus, Chatham; Representatives to National Committees: Miss B. L. Gregory, health insurance and nursing service; Miss A. A. Burns, history of nursing; Miss M. McMullen, eight-hour duty for nurses; Miss Marion Myers, exchange of nurses.

Mr. T. C. Mcnabb, General Manager, C.P.R., District of New Brunswick, was guest speaker at the dinner meeting; his topic was fortitude. The St. Croix Medical Association entertained the nurses at tea. An invitation from the Saint John Chapter to hold the 1943 annual meeting in Saint John was accepted.

ALMA F. LAW
Secretary-Registrar, N.B.A.R.N.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

A Comparison of Health Service in Elementary and Secondary Schools

W. V. GODARD

It has been stated by an authority on school nursing that the primary aim, which the nurse and all other health workers must hold constantly in mind, is opportunity for every child for continuous and satisfactory growth in control of conduct contributory to health. If we are willing to accept this as a goal, a comparison of health services in elementary and secondary schools will be more one of degree than of kind; suiting the program to the stage of maturation of the child—physical, mental, emotional and social, and to those needs shown from study of the vital statistics of the age group.

Growth is said to be the most striking characteristic of the child though it is uneven and irregular and varies with each individual. Height and weight cycles are noted by various writers and both boys and girls are very conscious of their appearance and most anxious to conform to the so-called norm., whereas the younger child frequently cares little or nothing about his appearance. Regarding mental growth, children with a lower I. Q. are apt to be retarded in motor, physical and sensory development but the problem is more academic than physical. Nevertheless the nurse should know the mental level and suit her service to the student's needs.

Emotional growth seems to vary even more than physical or mental development. However, there are broad general characteristics of the school age groups. Both elementary and secondary school children have desires for group recognition, for new experiences and for security. The younger child needs a greater assurance that he has love and protection from those adults with whom he comes in contact, whereas the adolescent wants to take this for granted and seeks understanding of his striving for independence. Both groups also wish for response or intimacy with one person, either parent, teacher, some especially liked companion or even a pet dog.

Children of all age groups are enchantingly unlike one another, but they are also alike. The boys and girls in kindergarten and first grades play well together, but later want groups of their own age and sex, organized or unorganized, as their chief social interest and they seek the approval of the group rather than family or other adults, especially after ten years of age. Gang play progresses to team play and by secondary school age there is a keen interest in competitive sports either as participant or observer and in other activities shared by both sexes.

During the so-called gang age, there

is a special lack of sympathy toward the opposite sex. Ethical standards, loyalty, fairness, self-reliance, and so forth are acquired in this period so that by the time he has entered high school the child has a fairly well-defined sense of social responsibility. His sins of omission are more thoughtlessness than ignorance. Though rebellious of authority he can be impressed when he sees the utility and necessity of authority and he is very ready to accept the rules from his own age group. Between the true gang age and the gradual returning interest in the other sex, there is in some children a negativistic period; in girls this may be at about twelve or thirteen years and in boys thirteen to fourteen years. They are unsocial, become critical, self-centred and selfish and fight with and against everything, and seek interest in sex.

The period from twelve to eighteen years is usually a healthy period. However, deaths from tuberculosis rise after fifteen years of age, excepting in those municipalities which have paid special attention to this disease. In girls, the tuberculosis curve rises sharply from fifteen to twenty years; for males it extends further into adulthood. Miss Ella Chayer in her book on School Nursing states "despite the fact that death rates and indices of illness are low, the physical status of the secondary school child is inferior in many respects to that of the younger group. Defects of vision are doubled, heart and lung conditions are greatly increased. Thyroid and skin disturbance and skin infections are prevalent and constipation and indigestion are so common as to constitute a major problem as so many of these conditions seem to have a direct connection with appendicitis". She also writes "the student himself is the only person who can make the necessary alterations in his mode of living. His education should develop in him a scientific attitude to serve as a basis for evaluation of present and future situations involving the fundamentals of living and the selection of expert medical service." This, it would seem, places a great deal of responsibility upon the shoulders of the adolescent, a responsibility he cannot carry to a successful conclusion without thorough education in the elementary school in healthful living, correction of his defects, control of communicable diseases and adequate immunization to be followed in the secondary school by intelligent guidance.

School health work in elementary schools has gone through at least three stages since its inception. The first phase was inspection to disclose and prevent spread of contagious diseases; the second emphasized examination to detect and bring about correction of physical defects. Added to these two is the third which is largely accomplished through teaching health systematically as part of the regular school curriculum. With these changing concepts, new methods evolved until we now have routines which make for efficiency in serving large numbers of children scattered in many elementary schools. The minimum nursing program as authorized by the Province of Ontario provides for rapid classroom inspections in September and January; classroom inspections in autumn and spring; vision tests yearly; preparation for the physician's examination of children in grades one and seven; home visiting and the recording of these activities.

Last year in St. Catharines 2625 hours were spent by the four nurses in elementary schools, plus other time in home visiting for service to 4118 pupils. The School Medical Officer spent four mornings weekly in the schools and did

618 examinations with parents present; 865 with parents' consent, and 676 special examinations, a total of 2159. Four hundred and five students graduated from elementary school; eighteen of whom had uncorrected defects other than dental. If this personnel and this amount of time is necessary to carry a program in elementary schools, what can we hope to provide in the secondary school where we are still in the pioneer stage.

The results of a recent study of school health services in Tennessee show that it might be profitable for us to re-evaluate much of our program. Their conclusions suggest the unproductivity of the frequent medical examination and other routine procedures; the relatively greater importance of service to the younger versus the older group; the value of a parent present at the examination and the importance of applying the resources of the community where they will do the most good. Frequent periodic vision testing is the only exception made to repetition of examination.

To carry the three functions: communicable disease control, direction and correction of defects, health promotion and education, we must have a healthful school environment. Inspection and advice of health workers are needed and the three functions are our responsibilty though the emphasis may vary. Communicable disease control is a lesser problem in the secondary than in the elementary. The main hazards are the common cold, influenza and tuberculosis; however, the students can and do protect themselves and others more than in the lower grades. This is partly due to the fact that most primary health habits have become automatic and, if our educational program has been good, he has an awakened desire for physical perfection. The anger of a high school student when he acquires german measles, which to him is a baby's disease, is quite illuminating, so also is the manner in which he is shunned by his fellows. He, however, accepts exclusion as a matter of course and quarantine is usually good.

Of the second function, that of detection of defects and the promotion of health, the Tennessee study states that "the parent is responsible for carrying out recommendations for the young child, but at adolescence or shortly after the child must begin to assume this as a personal responsibility. For this reason and because of changes which take place, a second medical examination should be offered at which the individual's history is reviewed, the present health status evaluated and recommendations made directly to the child for further improvement or protection of his personal health. Such an examination might properly be made in the early years of high school and might be made at different ages for boys and girls".

In a collegiate of 1200 to 1400 students, there will be from 450 to 500 entering each year. Can we give this number of students an unhurried thorough examination and explanation in the time the health staff can give? A hurried examination may be worse than none as it may fail to detect illness or defect and thus create a false sense of security. With this in mind, should the policy of physical examination of secondary school students be frankly stated as a rapid search for gross abnormalities and an exercise test of heart function or shall we attempt something more thorough?

In spite of careful follow-up, many children enter our high schools with known uncorrected defects. If the child and parents fail to recognize the need for correction when first notified, experience has shown that in most cases, they will not do so later. Which leads

one to ask with what type of health problem does the secondary school student feel he or she needs help? What are the health hazards from which he needs protection? What shall be the emphasis?

Undoubtedly, we should stress the third function — that of health education, both formal and informal. There should be tests and x-ray for tuberculosis, instruction in knowledge of nutrition and its practical application, dental care, protection of eye-sight, help in correction of poor posture, some sex education, determination of fitness for competitive sport, help with budgetting of time to prevent over-fatigue and to accommodate to the curriculum. The adolescent frequently hides his worries or broods over them, or his overt behaviour is difficult to control which means that we must provide time and opportunity for the student to express himself in one or more conferences which he feels are his alone. The understanding craved in this period is in the emotional and mental turmoil, their wish to master this turmoil, in their interest in physical development, in their interest in sex, in their desire for independence, in their leaning to social activity, in their interest in love and in their reconstruction of religious beliefs. To have and give this understanding, a worker must have faith in the adolescent, not overlooking his faults, but knowing them, still have belief in him and through goodwill, kindness and the desire to help, have patience not weakness toward him. To do this we must study youth through literature, we must have had experiences of our own, we must have contact with youth and the will to understand. This willingness to understand is not the function of the health workers only, but of the whole school personnel which brings us to the second aspect, that is, desirable relationships with the principal and classroom teacher and the teachers of household science and physical education.

A nurse assigned to school work becomes a member of the school staff and as such is responsible to the principal for the conduct of the school health service in the particular school. Although a nurse is a member of the school staff, we must not lose sight of the fact that we are members of one profession invading or invited into the province of another profession. Miss Chayer has emphasized this point: "the school nurse must be professionally prepared to relate herself to the health services . . . therefore, she must be competent within her own professional field of public health nursing. But more than this is expected of her; she is carrying on her activities within an educational system with whose philosophy, aims, methods and administration she must be familiar, and to which she must relate all she does."

What then is the relationship between the principal, the classroom teachers and the nurse? Before making a schedule of work the nurse should submit a tentative plan. The approved plan is then announced to the teachers by the principal who may or may not ask the nurse to give further details to the teachers. The principal can expect that the program once set up will run on schedule; that any extra activity such as tests for tuberculosis, will be planned well in advance; that periods of school work will be long enough as to make economical use of time; that appointments for pupils in the health room will take the minimum necessary time from their academic work and that matters of major importance will be reported to him promptly. What the nurse wants most of all from the principal is that he will recognize and promote desirable health service and health education

standards. Relationships with the classroom teachers will in general follow the attitudes and practice set by the principal.

Effective relationships with the household economics teachers is of mutual benefit. Children in this department are frequently from less privileged families. Classes as a rule are smaller and the teacher knows the students' problems. She is thus able to refer students needing health service and guidance and endorses recommendations for correction of physical defects, mental attitudes, and faulty nutrition. The health room linen provides material for laundry lessons. There is also excellent opportunity for co-operative teaching, the nurse contributing to content, the teacher to method.

Close relationship with the physical education teachers is of paramount importance. They are the only other workers trained to detect deviations from the normal and can refer many boys and girls. These teachers have more informal contacts with the students and, therefore, the pupils are inclined to confide in these instructors, especially worries over home and school conditions, also emotional disturbances and social activities. An unhurried conference with the nurse or physician frequently clears up many of these problems, or the more serious ones can be referred to specialists in the community. Again here is opportunity for co-operative teaching. The physical education teachers teach the formal classes on health and they instruct and encourage the students in recognizing their own health needs and to voluntarily seek expert advice. The physician and nurse in return supply factual scientific information and source materials as well as giving health service. If the nurse is expected to teach home nursing there should be adequate equipment.

The physician and nurse as members of the staff should attend the teachers' meetings, but more important than periodic conferences is continuous team work and a unified program for the whole personnel, not many unrelated activities. Each worker must appreciate the fundamentals of child guidance if we are to keep as our aim: "For every child continuous and satisfactory growth in control of conduct contributory to health".

Beware of Fraudulent Agents!

A fraudulent agent is playing his mean and miserable tricks in the Prairie Provinces and one of these plausible thieves even had the audacity to call on the registrar of the Saskatoon Registered Nurses Association. Fortunately she was on the alert and describes the interview as follows:

Recently a man called at our local registry, wanting a list of our nurses, for the purpose of soliciting subscriptions to *The Canadian Nurse*. He said he had undertaken the work of obtaining subscriptions in Edmonton, Alta. I told him I could not understand his calling as we had our own local and Provincial representatives to the *Journal* and asked him for his name and identification, which he did not give and immediately said he had to go out of town for three or four days and would call when he returned. Of course I did not give him our list of nurses, and a week has passed and we have heard no more from him.

Once more we repeat the sad warning — the *Journal* employs no agents. Anyone who claims to be one is a fraud.

Educational Aspects of the Toronto Health Service

EILEEN CRYDERMAN

Before giving an interpretation of how the Health Service aids the hospital staff in the bringing of health teaching into the undergraduate curriculum, it is perhaps well to explain that this particular department in the various general hospitals in Toronto (with the exception of the Toronto General Hospital), together represent one of the nine units of the Nursing Division of the Department of Public Health of the city of Toronto. The nurses in this unit serve sixteen hospitals and are placed according to the need of the individual hospital. Here the Health Service attempts to act as a link between hospital and home, by interpretation of the patient to the medical and nursing staff, and by endeavouring to make sure the patient not only understands the doctor's orders but can carry them out. In acting as a liaison officer between patient and hospital, the health service nurse works very closely with the public health nurse in the district, and through her with the community resources to help meet her objectives.

It is felt that the teaching of health in the undergraduate curriculum is primarily the responsibility of the hospital administration. But, as the Health Service is an integral part of the hospital, it is thought that until such time as there is a public health nurse in each hospital, responsible for that part of the curriculum, it should lead in the general interpretation to the junior student of what the Health Service stands for, its purposes, functions and how these are carried out. In this way, if the student is interested, she may obtain at least some conception of the role of the public health nurse in the hospital and in the district.

The following is a brief outline of what is attempted for the undergraduate student: the students all come to the Health Service at some time during their junior year and, at stated intervals, a centralized illustrated lecture is given to a group from all the hospitals participating in this plan. Slides are shown depicting the work of the public health nurse in the field and how her work is related to the Health Service worker and so to the hospital. The individual hospital is responsible for the giving out of mimeographed copies of a resumé of this lecture. Each student is assigned for one week of Health Service experience, three and one-half days of which is spent under supervision, and the remainder of the week in the out-patient department or ward as arranged by the superintendent, the student being subject to call should an interesting experience arise in the Health Service. One of the primary objects during this week is to enable the student to gain some understanding of the conditions under which the patient lives; some of the problems of community living which may affect the patient's recovery; what opportunities the patient may or may not have for carrying out the doctor's orders; and community resources for helping meet these needs. The student observes the admission of patients in the out-patient department and follows a suitable patient through the clinic, staying with her the entire time she has to wait, endeavouring to learn unsolicited facts about her reasons for being at the hospital and about her work and family. The student may

stay with her until she is in bed thus acting as a hostess to the new patient entering hospital. This helps the student, who after all is very junior, to use her own initiative and to have a better understanding of the problems of the patient.

The student also observes a little of the general clinic routine but is there primarily for the observance of the Health Service work in selected clinics such as the chest, diabetic, obstetrical, venereal disease and, in the Hospital for Sick Children, the heart and orthopedic clinics. Here she is able to link up what she has been told is the purpose of the service. For example, in the pre-natal clinic she sees the worker interviewing Mrs. Brown, after she has seen the doctor. This is Mrs. Brown's first baby and the first time she has ever been at a hospital clinic. Naturally she has been under quite a strain, and comes out not too sure what the doctor really has told her. The student is able to observe the nurse going over Mrs. Brown's chart, interpreting the doctor's orders, taking up any problems the patient may present herself, and giving the amount of teaching that is advisable during a first interview. She learns that Mrs. Brown is told that the public health nurse in her district will be coming to see her at home, and how she may contact her, if she wishes to see her in the meanwhile. The student later sees the report the Health Service nurse writes for the public health nurse in the district. Or, as another example, Mrs. Jones has been referred from the medical to the chest clinic; the doctor finds she has a moderately advanced active pulmonary tuberculosis, and tells her she must have the care that only a sanatorium can give her. The doctor in a busy clinic has very little time to give Mrs. Jones other than that required for the instructions he wishes her to follow. The student sees Mrs. Jones being sent to the Health Service nurse to make sure these orders are understood and can be followed. She observes that Mrs. Jones is very disturbed —if she goes to a sanatorium who will care for her family? The student realizes that the worries uppermost in the patient's mind are her children and her dread of going to a sanatorium. She observes the nurse dealing with the points of primary importance. Here, too, she hears the patient being told that thenurse in her district will be in to see her soon, and is later told how the public health nurse in the district carries on with the teaching, the preparation for entering sanatorium and the instructions regarding the examination of contacts. Besides observing the Health Service nurse in the clinics the student accompanies her to the ward to listen in on a conference with the head nurse, and an interview with a patient.

This experience is a joint responsibility in that two days of each week are spent in some other department of the hospital and, at that time, the student does not come under Health Service supervision but that of the head nurse or supervisor. The importance of the teaching staff participating in and knowing the significance of the work and what the department is trying to do for the student cannot be stressed too much. The Health Service nurse does realize that part of her responsibility lies in the interpretation to the staff, so that the head nurse may aid the student in the correlation of this experience with her bedside work. It is necessary to reiterate the dependence of the Health Service nurse on the supervisor, the head nurse and the student for learning the patient's problem before aid can be given in solving it. The student has a very vital part to play in this. Can she not be taught the importance of her bedside conversation with the patient, for it is undoubtedly

her own nurse, the one who is bathing her and looking after her immediate needs, that the patient will confide in? At this time the student may also share in the teaching of health both from the curative and preventive angle.

The Health Service has no direct responsibility for the program of the intermediate and senior nurse but the School of Nursing carries out a plan with the aid of the hospital, the Health Department and the bedside-nursing organizations. A month's experience is available during which one day a week is given to lectures, reading, and essay work; two days are spent with a field supervisor; and the remainder of the week on duty in the hospital. The superintendent is responsible for seeing that these days in the hospital afford an opportunity for the correlation of health teaching with bedside work. The Health Service can only act in an advisory capacity but students are encouraged to come at any time, and although this is being done to some extent it is felt that many could come more frequently. Some phase of public health work comes into many of their conferences and demonstrations, and the Health Service worker could sometimes be of help in interpretation. The head nurse is encouraged to allow the student to come at times, with a patient's problem she has herself discovered.

In short, the objective of the Health Service in participating in the undergraduate curriculum may be summed up in a quotation from an article written by Miss Katherine Tucker: "To have students see patients, first as people and second as patients, so that this picture can never be disentangled because it has penetrated into the student's feelings and she learns that, for these human beings in the hospital, health, to be an activating force, must be translated into their own terms, their needs, interests, understanding, desires and capacities."

A Recent Appointment

HELEN E. PENHALE

Miss Helen Eileen Penhale has recently been appointed to the teaching faculty of the Division of Study for Graduate Nurses at the University of Western Ontario. She is a graduate of the School of Nursing of the Mount Sinai Hospital, New York, where she was medical supervisor for three years. After a year of private duty, she became instructor at the University of Michigan Hospital, and subsequently joined the chemistry department at Columbia University. She was in charge of staff education and ward instruction at the Massachusetts General Hospital for one year, and then became nursing education instructor at Boston University. Miss Penhale has taken a postgraduate course in psychiatry at the Bloomingdale Hospital, New York, and holds the degrees of Bachelor of Science (Nursing) and Master of Arts.

Contributed by the Hospital and School of Nursing Section of the C. N. A.

The Integration of Health and Community Aspects in the Basic Course

MARGARET STREET *and* IRENE HARVEY

The maintenance and promotion of health forms an integral part of the nursing function, going hand-in-hand with the prevention and cure of disease. The concept of health, in its most far-reaching personal and social implications, rightly constitutes the very life-blood of the curriculum, running through and vitalizing every learning process whether in classroom, laboratory, at the patient's bedside, in the clinic, or in home or community. Miss Katherine Tucker has given vivid expression to health aims which should activate the nursing curriculum, in these words: "We are concerned with how to incorporate the health approach into every part of the Curriculum of Schools of Nursing, not as a separate nursing function, but so that all nursing knowledge and skill will lead to the restoration, preservation, and attainment of health." The objectives, then, are clearly defined and it remains for schools of nursing to see that they are realized. In order that they may be, certain conditions must be fulfilled. All members of the staff of the school must share whole-heartedly in the common purpose: to be health-minded and desirous of imparting the same philosophy to their students; to be well informed upon matters pertaining to public health movements; and to be acquainted with community health facilities and organizations. In this connection it has been suggested that sending students out into the community while head nurses and supervisors are entirely lacking in such contacts, is equivalent to putting the cart before the horse.

Another prerequisite to a realization of our health objectives is a healthy personnel in the hospital itself. This necessitates favorable environmental conditions, physical and social, in the nurses' residence and in the hospital; hygienic working conditions, including adequate provision for recreation and rest; and the maintenance of an active health service for students and staff. The school of nursing must also possess the necessary facilities for the teaching of health such as well-equipped classrooms, laboratories and wards; active and varied clinical services, including out-patient and social service departments. If possible affiliations should be arranged with public health nursing agencies and other community organizations.

In general, the integration of health in the nursing curriculum, is accomplished in four ways: through maintenance of the student's own health; through classroom instruction; through

clinical experience; and by means of the out-patient and social service departments and community affiliations. One hesitates to draw an arbitrary line between any of these vital aspects of the nurse's education. They are so closely interrelated and mutually dependent that they are really one, just as body, mind, and emotions make up the whole person. It is particularly difficult to discuss separately classroom and clinical teaching; one shades off into the other and they should blend harmoniously into a strengthened whole. However, for purposes of analysis, we shall attempt to trace the development of the health concept in the Curriculum under the four headings to which reference has been made.

Health Service: Until recently the health program for students, which was excellent in many hospitals, was designed to keep the staff at maximum efficiency. Now, in addition, its use in offering opportunities for integrating health into the curriculum is realized. Personal charts are used to demonstrate the possibilities of health examinations and the student's interest in her own health will lead to the developments of habits, attitudes, and knowledge regarding health promotion and the prevention of disease, first for herself and, by larger application, for those who come under her care, and finally for the community as a whole. In addition, the nurse must be able to demonstrate in appearance and in practice that which she is attempting to teach.

The use of instructors who are experienced in public health nursing, is invaluable and is recognized as a wise procedure in associating curative and preventive aspects and in linking up inside and outside services. These instructors also assist materially in guiding the application of mental hygiene thus helping students to adjust to new situations and to understand the reactions of others.

The health service should include preentrance and entrance examinations excluding those who are physically or emotionally unfit. The entrance examination should be thorough and should include chest x-rays, physical examination and laboratory tests. Personality tests are being used more and more to determine the student's emotional fitness for nursing. Periodic examinations should be made and weight scores kept throughout the course. Health supervision should encourage the early reporting of illness and emphasize the importance of recognizing minor complaints as forerunners of potential illness. A friendly atmosphere is essential to overcome the reluctance of nurses to pay attention to minor conditions. Some hospitals have found it desirable to allow the students two weeks sick-leave without adding to her time so as to encourage reporting of illness early. Correction of defects by means of foot clinics, etc. should be undertaken. Mantoux tests should be made before and after assignment to duty in the tuberculosis service. Immunization is necessary against typhoid, diphtheria and small pox. A study should be made of the causes of illness among students, seasonal variations, incidence, etc., by the students themselves. Nourishment between meals and cod liver oil may be found necessary. Hospitals which supplement the diet during the winter months by giving cod liver oil capsules to their staff are able materially to reduce the number of days of sickness due to upper respiratory infections. The Curriculum of the National League of Nursing Education states that "health conservation and the prevention of disease is inherent in the whole concept of nursing and should be a part of the student's preparation from the beginning." How can this be accomplished better

than through her personal health program as maintained by the hospital health service?

Residence life and recreation: Residence life should afford the student the opportunity to see and experience the practical application of hygienic living. Students learn about health through favorable living and working conditions, and this means the adjustment of the educational plan in its relation to hospital and residence conditions. The routine of student life should be so ordered as to ensure a complete health program, including rest, diet, recreation, time for study. Facilities for privacy and comfort should be provided; the students should have single rooms, sufficient bathroom facilities (minimum of one bathroom to six students) and laundry facilities. Provision should be made for outdoor and indoor sports. Time and opportunity should be afforded for reading and music (mental hygiene in practice), and sufficient off-duty activity to discourage "post-mortems" of ward experience. The health office in the nurses' residence, with a competent and experienced graduate nurse as director, is of great value and should afford guidance in making physical and mental adjustments, both by formal and informal private discussion.

Classroom and clinical experience: Health cannot be taught effectively in a formal course of study; it enters into every subject in the Curriculum. Yet for the guidance of the young student, instruction is given in the principles of personal hygiene. In the words of the Proposed Curriculum, this instruction should be "less factual and more functional", and have as its aims the improvement of health attitudes and practice of the students themselves, and the provision of instructional material to equip them for health teaching.

Instruction in principles and methods of teaching health is usually given in the second year of training. The student learns, under supervision, when to teach, how much to teach, and the best time to teach health. Instruction given to the patient by the nurse is in direct relation to his needs and wants; this necessitates an understanding of the patient as an individual, the disorder from which he is suffering, and something of his home and community background. Specifically, the nurse may teach bodily cleanliness, care of the teeth, of the hair, the value of a well-balanced diet, of fresh air and sunshine, or she may be required to demonstrate a procedure which the patient will carry out at home. The nurse herself must exemplify in her own person the principles of good hygiene.

Basic sciences: The basic sciences, including chemistry, anatomy and physiology, and bacteriology, are included in the Curriculum to provide a body of scientific knowledge from which nursing principles are derived. They enrich and strengthen the student's concept of health in its personal and community aspects. For example, in teaching chemistry special emphasis may be placed upon the physiological values of water and upon methods of purification. An excursion to the municipal waterworks would be valuable at this time. So, too, in the study of oxygen, stress will be laid upon its function in supporting life and supplying energy, as well as upon its therapeutic uses.

The study of anatomy and physiology seeks to give the student an understanding of the structure and function of the normal healthy human body. This knowledge serves as a guide to the recognition of deviations from the normal and as a scientific source from which nursing principles may be derived. Every lesson could well end on a health note. For example, a discussion of bone

tissue affords an opportunity to correlate anatomy with nutrition, personal hygiene, obstetrics and paediatrics.

Bacteriology is correlated with the other basic sciences and with the nursing arts, as also with community nursing problems. Excursions to the city bacteriological laboratory will help the student to appreciate the value of bacteriological principles and practice in the protection of the community. The student should gain some understanding of the growth and significance of the public health movement through a study of the history of bacteriology, and especially of the work of such men as Lister, Koch, and Pasteur. The safeguarding of society by immunization programs and the responsibility of the nurse in teaching the value of immunization would be emphasized. The student will thus be equipped to give more intelligent nursing care to patients suffering from communicable disease, and to prevent the spread of infection to others.

Nursing arts: Orientation of the young student to the hospital and school of nursing is so planned as to give her an appreciation of the place and function of the hospital in the community and of the importance of environmental control in relation to the health and safety of the patient. Tours of hospital departments and of community health agencies help the student to obtain a bird's-eye-view of the whole plan and opportunities for integration of health factors are legion. For example, the social significance of heart conditions, the anemias, carcinoma, tuberculosis, and venereal diseases must receive particular emphasis, as must their bearing on mental health. Obstetrics is a field in which almost unlimited opportunity is given for observing the normal and which can be used to great advantage to demonstrate the nurse's role in public health.

Out-patient department and social service: The aims of this specific experience are to view the work of the hospital from without; to supplement clinical experience on the wards; to enlarge the student's knowledge of social and community problems; to afford contacts with outside social and health agencies. The student will learn to interpret social factors in health and sickness situations in her own work and to help patients in their social adjustments. Conferences should include the discussion by physician, nurse, medical-social worker, psychiatrist, and dietitian of some individual patient presenting problems in all these fields. A family report, by five or six students working together, illustrating the consideration required to meet the associated problems of a family unit, would afford opportunity for observing results of teaching and the health practices of patients, as well as evaluation of standards of living. This study should be presented orally and an opportunity for discussion afforded.

Community experience: This experience is included in the Curriculum to serve not as an introduction to social and preventive aspects of nursing, but as a supplementary nursing experience in which the student will meet some of the more common situations found in family health work, and will obtain practice in dealing with them. Such affiliation necessitates competent educational direction and supervision in the department or organization concerned. The factors of supervision, time and experience must be considered and the educational preparation and experience of the student must be such as to make such opportunities valuable. In a word, the whole affiliation must be planned and carried out as an educational procedure. The employment by the hospital of educational directors and department heads with community experience will

materially aid this plan. The public health point of view may be furthered by inter-representation on boards and faculties of educators and hospital members, thus giving the personnel of the hospital a broader conception of the place of public health in community welfare.

Conclusion: As Mary S. Mathewson has said: "the health aspects of the undergraduate nursing course may be said to include knowledge of normal, healthy individuals; measures for keeping them in health; measures for the prevention of preventable diseases, and for the protection of the community from infected individuals. The integration of the health and community aspects throughout the basic course is a fundamental issue."

We Go on the Wards!

Last autumn it became apparent that a severe shortage of civilian nurses would come about as the result of the large enrolment for overseas service. I have been married for seventeen years and therefore felt the need for brushing up. So, with four other members of our Alumnae Association, I approached Sister Mansfield, and the Superior of Holy Cross Hospital in Calgary, and asked permission to go "on the wards".

We all started at 8 a. m. and stayed till 5 p. m. and were on duty for a month. My own month started with a week on a ward which comprised female medical and surgical patients. I assisted one of the third-year students with her patients and saw all the treatments given—such as catheterization, douches, intravenous, transfusion, Wangensteen, steam kettle and tent, radiant heat, lumbar puncture and many more. The next week I spent in the central dressing room and from there I went to the obstetrical ward for a week. I helped with the care of the patients and was much interested in the labour and case room service, especially the new sedation. The fourth week I spent most of my time between cases with the internes watching them do treatments which are out of the nurse's jurisdiction. The other four nurses in our group divided their time a little differently and were on duty in the surgery and on the children's ward.

After this was all over we decided we needed some lectures by doctors so we organized an extensive two-day series for all the graduate nurses in the city. Once again, with Sister Superior's kind permission, we had the use of the lecture hall and all the necessary equipment. These lectures were attended by nurses from nearly every well known training school in Canada, and some from the United States. We even had one who graduated in Switzerland. Our first lecture was given, by Dr. Clara Christie, on obstetrics and measures that could be used in case of an emergency. Miss Geraldine Norman, dietitian at Holy Cross Hospital, spoke on special diets, and the rest of the afternoon was taken up with demonstrations and classes. In the evening, Dr. Scarlett lectured on materia medica and the drugs necessary in emergency work. Dr. Johns also spoke on anaesthesia. On the following day, Dr. Jennings lectured on diabetes and the use and administration of insulin. The afternoon was taken up with more demonstrations and a tour of the Hospital when new equipment and its use was explained. In the evening Dr. Melling gave us a very interesting talk on mental cases, and Dr. Cody told us about recent advances in pediatrics. Since our little adventure other nurses have gone in and spent a month and we really feel that we are ready for anything that comes our way.

(Mrs.) A. T. Kloepfer

Secretary, Holy Cross Alumnae Association
Calgary

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

A Blood Donor Service in Halifax

FRANCES BROWN, B. A.

There is always the need of blood for transfusion purposes, especially so in time of war for civilians as well as for the armed forces. During the first great war mobile blood banks were established, but these were found unsatisfactory because whole blood cannot be kept more than a few weeks. In September, 1939, work was begun on the extraction of serum from blood and its preparation in dried form under the direction of Dr. C. H. Best at the University of Toronto. This research led to a process by which the serum could be completely dried. The final product is easily transported and can be kept for a long time and, after the addition of sterile distilled water, is convenient to use. The indications for its use are those which normally call for a whole blood transfusion. In cases of shock from burns, where the condition is due to the loss of serum, the reconstituted dried serum is ideal and should be used in a twice-normal concentration obtained by adding only half the normal amount of distilled water. In cases of extensive hemorrhage, with or without severe shock, the dried serum is the best emergency blood substitute, but should be followed, if necessary, by a whole blood transfusion as soon as possible. In shock without hemorrhage, there is loss of blood volume due to the loss of plasma, which escapes through the capillaries, thus increasing viscosity. This condition calls for serum more than for whole blood.

When the worth of this dried serum as an agent for the treatment of war casualties was proved, the Federal Government through the Department of Pensions and National Health requested that the work be extended. The Canadian Red Cross Society agreed to establish clinics across Canada, accommodating three thousand donors a week, to obtain these donors, and to transport the blood or serum to the Connaught Laboratories in Toronto. The Government also agreed to provide funds to finance the processing of the blood by the Connaught Laboratories. Clinics have been established in most of the larger cities in the Dominion, and are shipping a constant supply of blood or serum to Toronto.

In Nova Scotia, the central clinic is in Halifax, where we handle an average of one hundred donors a week. To become a donor, one must be a healthy individual between the ages of 21 and 60, and for women the hemoglobin must be normal. Some people think that women are not suitable donors but our experience in Halifax, where women make up over half our lists of donors, is

that we have more reaction among men than among women. The donors make appointments through our office to come either on Monday between 9.30 a.m. and 12.30 p.m. or on Wednesday between 5.30 p.m. and 8.30 p.m. They are asked to refrain from eating fried foods or foods containing fat, and to drink plenty of fluids on the day of donation. This is because the eating of fats makes the serum fatty, which means that the resulting dried product is oily and not satisfactory to use. Therefore we must discard all fatty serum and no one who has given his blood likes to think that it was useless. The extra fluid is to help the donor make up for what he loses and also may give us a larger yield of serum.

At the clinic, the donor is greeted by a member of the nursing section of the Women's Volunteer Corps of the Red Cross. His name is taken and he is given a slip of paper with his name and a number on it as well as a donor book and a record slip for our files. The slip of paper with his name will be put on the bottle into which his blood is taken. If he is a new donor he is sent to the technician, who types his blood and, in the case of a woman, takes blood for a hemoglobin test. Following this he goes back to the reception nurse who takes his temperature. He removes his coat and rolls up his sleeve and, as soon as a room is ready, goes in. There he is met by a graduate nurse who takes his slips and donor book and makes him as comfortable as possible on the donor table. His arm is washed with green soap and water and then with iodine and alcohol the tourniquet is tightened and the doctor injects a small amount of local anaesthetic, in this case Stocaine, one-half of one per cent, into the skin over the vein. The donor needle is inserted with very slight discomfort to the donor. The needle is large, a no. 16 gauge, and the blood generally flows freely. The donor is given a small rubber ball to squeeze and if the blood still does not run well a little suction is applied by means of the nurse sucking the mouthpiece. When 400 c. c. have been drawn off, the doctor takes out the needle and a small sterile dressing is applied to the arm. The donor lies quietly for a few minutes and then if he feels all right he goes into the recovery room where he is given a cup of tea or coffee and biscuits. After resting for half an hour, the donor is ready to leave. The only reaction generally noted is moderate fatigue and excessive thirst.

After the clinic is over, all the blood is taken to the laboratory where, after standing for a few hours, the connections are removed, the clot is cut and a sample is taken from each donation for a Kahn or Wassermann test. The blood is left in the refrigerator overnight and, in the morning, as much serum as possible is drawn off the blood clot into 250 c. c. centrifuge bottles. These are centrifuged at 2000 r. p. m. for half an hour and then the supernatant serum is pooled into four-litre bottles as soon as the report of the Kahn tests is received. Samples of this pooled serum are taken off and planted in nutrient broth and on a poured agar plate and merthiolate is added as a preservative. These sterility tests are read at the end of a week and if the media show no bacterial growth, the serum is sterile and is ready to be shipped to the Connaught Laboratories. There the serum is put into large metal containers and then is forced through fine asbestos filters into large sterile bottles. Later, 250 c. c. is measured into smaller bottles, with paper-covered rubber necks, and immersed in alcohol cooled to 40 degrees Centigrade with dry ice, to freeze. When frozen, the bottles are place in racks and the paper covers removed. They are then placed

in the vacuum cabinet and dried at a very low temperature in order not to alter the proteins chemically. These bottles are put into tin containers, sealed, and shipped to Ottawa, from which centre they are distributed to our Canadian Forces overseas and to centres in England for use by the civilian population. Of course a generous supply is kept in Canada for use in an emergency.

Here in Halifax, all the work that is not of a technical nature, is done by volunteers. The Clinic is staffed by about ten or twelve graduate nurses who are married or not in active work. There are also from six to ten members of the nursing section of the Red Cross Women's Volunteer Corps who take temperatures, make and serve refreshments, and look after the recovery room under the watchful eye of a graduate nurse. The work in the laboratory, such as washing glassware and rubber tubing, making up the blood sets into which blood is drawn off, and serum sets used to draw the serum into centrifuge cups, and the centrifuging itself, is all done by volunteer help. These volunteers come from various organizations in the city, such as the Junior League, the St. John Ambulance, and the auxiliaries of the Red Cross and the I.O.D.E.

We find that many people are anxious to become donors. They feel there is so little they can do to help and this seems to them, as it actually is, a very personal effort, something that no one else can give, four-fifths of a pint of their own blood to save the life of some soldier, sailor or airman, or of some woman or child wounded by German bombs. England wants more serum and more donors are needed all over Canada. Why don't we all try it?

A Voice from the Past

In years gone by we gave, to the senior girls in the public schools, a course of instruction in the care of babies. The girls had to write an examination and only a few weeks ago we found a manuscript, which recorded some very original answers to the questions—"Why is breast milk best for babies?" There is no doubt that they will prove helpful to the nurses, even the bright young ones of the present day, when they are teaching in the homes:

Because mostly bottle fed babies dies when they is young.

Because it protects from community deceses.

Because it is protected so that cats and dogs cant get a lick at it.

Because it prevents municipal diseases.

Because it is handyer in a trip.

Because it does not go sower. .

The last answer in the collection, came we can be sure, from a dear good little girl. It is "Because it comes from God."

On one occasion when Bessie Elliott was taking part in this service, it was quite observable that she was overcome by one of the answers and it was quite a little time before she recovered from her emotion sufficiently to return to her work. When the marking was over, we heard what had affected her. It was an answer to the question—"What should a baby wear on a warm summer day?" The answer was—"A tin shirt and a dipper".

—*"Stepping Stones"*

STUDENT NURSES PAGE

In Charge at Night

JANE M. JOHNSON

Student Nurse

School of Nursing, The Moncton Hospital, N. B.

It was with mingled feelings that I learned that I was to go on night-duty, in charge on a private floor. "In charge" has an ominous sound, but I determined to do as good a job as possible, assisted by my two juniors, who were above the average in intelligence and willingness. We decided that each nurse should have the same patients nightly because the management had decided it was best to have a certain nurse assigned to certain patients. There were various reasons: the patient would relax more under a familiar hand; the nurse, knowing his general condition, is more able to observe a change, knows his likes and dislikes, and is better able to please. Then, too, our instructress had established the practice of writing case studies — she says it increases a student's powers of observation, interest in the patient, and general knowledge of the disease. All of us had to be familiar, none the less, with all the patients, so that a nurse from one corridor would not offer a patient in the other corridor (who had had a tonsillectomy) a hot drink, thus destroying the confidence and sense of well-being we were trying to build up.

On night duty you are under less supervision than on day duty. You must plan your work well and work rapidly. But you must never give the impression of so doing; it is very irritating to most patients. There are two corridors on our private floor — a long and a short corridor. The night supervisor decided that the senior of my two helpers should have the long, and the junior the short corridor. Each one would be responsible for her own bells, and the 8 o'clock temperatures. In the meantime, I was to give the laxatives, make out the drug list, and answer the telephone. It worked fairly well, although there seemed to be a great many bells ringing, and we were dismayed to find it took so long to give the medicines and take temperatures because we were constantly interrupted. With a little co-operation from the day nurses we began to avoid this. The patients were left comfortable and, with drinks on their tables, rarely rang until we had time to get our preliminary work done. There was also a little difficulty about visitors. Most people do not realize the value of time (even a few minutes) to a nurse. We finally settled this by mentioning to the patients that the corridor lights would go out at 9 o'clock and that this was the signal for all visitors to go promptly.

We had 36 patients, including those having special nurses and, considering

the routine care given at our hospital, it kept the three of us fairly busy. Special nurses, of whom there were from 3 to 6 for the patients most ill, were a boon to us. Everyone comes in contact, sometime or other, with the wilful, the deliberate prevaricator, the fussy patient. For patients are people. All nurses have had the experience of leaving a room only to have the bell peal behind her, to re-enter the room and perform some trivial detail, and of not being able to reach the desk before the bell rang again. I used to think of Poe's line: "*The bells, bells, bells, bells, bells, bells, bells.*" After one such momentary rebellion inside, I talked with our superintendent. She had the perfect answer — "But it is unfailing patience that makes a nurse, isn't it?" I decided that one nurse in ten is born — the other nine are people who learn to be nurses.

Routine care consisted of offering the bed-pan, bathing the face and hands, brushing the teeth, rubbing the back with alcohol and powder, giving a hot or cold drink, straightening the bed and brushing out crumbs, tidying the room, and giving an extra blanket, opening the window. This was routine but it varied according to the patient's wishes. There still are people who dislike having their backs rubbed, and many male patients think it ridiculous to wash at nine at night! Most of the women had make-up on, perhaps that is why more of them washed!

We were taught to use every available method to induce sleep without resorting to a drug. We were pleasantly surprised to find how many times a change of position, a back-rub, a hot drink, or a soda tablet hinted at as a potent sedative, would induce slumber. Sometimes what the patient needed was not anything material, as in the case of Mr. B., who awoke with nightmare because he had two boys on their way to England. All he needed or, I should say, all we could give him was a few minutes reassuring conversation. But he told us he always slept afterward, "seeing how silly a dream is after all". He had all our sympathy. A patient said one night that nurses "have the ability of doing menial tasks with a faint reserve that far removes them from any familiarity", and we thought that a very nice compliment. The orderlies we found prompt and obliging, qualities perhaps more appreciated in the wee small hours.

We enjoyed our time off, which included a half-night a week, when we were relieved by a graduate. I must explain that we also had two hours off each night. From 12 to 2, 2 to 4, or 3 to 5, we found to be the best hours, as it left two nurses on the floor the most of the night. We had an excellent supervisor, who stood not on the cold formality that is slightly frightening (or discouraging) when one needs advice, but was always to be found, gave us our supplies of drugs regularly so that we could give them promptly, and was always cheerful and ready to help us in any dilemma. We came to a keen appreciation of the fact that the management saw that we had extra hands when we needed them, and loaned them when we did not. This, we conceded to be the mainspring of efficiency — co-operation. The endless co-operation between the nurses who work through the day, and the nurses who see the patients through the long vigil of the night is essential to a hospital.

The Professional Nurse

C. Hopkins

Student Nurse

School of Nursing, Saskatoon City Hospital

"Professional nursing is the blending of intellectual attainments, attitudes and mental skills based on the principles of scientific medicine and acquired by means of the required training in a school of nursing affiliated with an approved hospital, in conjunction with curative and preventative medicine." A professional nurse is one who has met all the legal requirements and practices or holds a position by virtue of her professional knowledge and legal status. The ruling spirit should be the desire to render a specialized service rather than to make money.

A professional nurse should be able to adjust herself intelligently in relation to the patient and his family. She should do all that she is reasonably able to do to aid in the patient's mental, physical and spiritual comfort. She must treat them as she would treat her own friends—as persons. She must watch carefully that her own attitudes and actions are above reproach. She must be prepared to appreciate, understand and adjust herself to all the different types of persons differing in such things as race, religion and personality.

With the medical profession, she must show technical skill and good judgment. She must be loyal and considerate and willing to follow direction. She must be conscientious in carrying out all orders for the proper care of the patient. She should become familiar with the different ways in which the doctors work in order to maintain smooth relationships. She must always be considerate and co-operative with other personnel with whom she daily comes in contact such as dietitians, social service workers and others. She must be loyal and co-operative with her colleagues and superiors.

The professional nurse also should play an important part in the community. She is responsible for carrying out efficiently what the public expect of the nursing profession which is "prevention of illness and disease, the promotion of health and restoration from sickness." Poise is an essential quality of the professional nurse. She should study herself in order to know what traits of personality and appearance she should possess and strive to acquire others which she lacks. She must overcome any that may mar what otherwise would be considered a well-balanced personality. Good physical and mental health is important. Health and cleanliness are the keynotes to personal appearance, and the professional nurse must always be at her best. She should present a wholesome, attractive, well-kept appearance — the back-bone of which is good posture.

Conversational ability is a necessary attribute. She must know when to talk as well as what to say and, better still, what not to say. She should share the conversation with others, not monopolize it. She should develop the art of being sensitive to people's moods and act accordingly in all situations. This rare gift is spoken of as tact. Her manners should be gracious at all times, and her ideals and practices must be above reproach in more than an ethical sense. Ethics in nursing has to do with ideals, customs and habits which members of the profession are accumulating by degrees.

Living conditions are most important to the professional nurse. Her residence

should be homelike, attractive and suited to her needs. Leisure activities should have no connection with her work, and she is a wise person if she chooses members out of her profession as associates. A change is as good as a rest is more than true in this respect. A professional nurse must live a well balanced life if she expects to do the best of which she is capable—and outside interests and activities provide this balance.

Just stand aside and watch yourself go by
Think of yourself as "Her" instead of "I"
Pick flaws, find fault, forget the nurse is you
And strive to make the estimate ring true.
The faults of others then will dwarf and shrink
Love's chain grows stronger by one mighty link
When you with "Her" as substitute for "I"
Have stood aside and watched yourself go by.

Esther Augusta Rothery

Following an illness of some months Esther Augusta Rothery died on September 4, 1942, at her home in Weston, Ontario. While in failing health for sometime and with certain knowledge that her days were numbered, Miss Rothery carried on to the limit of her physical powers, and had completed arrangements for the graduating exercises in May before she relinquished her duties as superintendent of nurses at the Ontario Hospital, New Toronto.

ESTHER AUGUSTA ROTHERY

Miss Rothery was born in Niagara Falls where her father, the late Jesse Colquhoun Rothery, a Scottish engineer, was engaged at that time in the development of electric tram lines. Later her parents moved to West Virginia but her secondary school education was finally completed at Harbord Collegiate Institute, Toronto. In 1916, Miss Rothery entered the Massachusetts General Hospital at Boston for training. Following her graduation she held a staff position in the hospital until she became superintendent of the Aurora Hospital, Illinois, where she remained for five years. On her return to Canada she entered the University of Toronto School of Nursing for graduate study and then followed a year in special training at the Ontario Hospital, Whitby. Following this preparation for administrative work in the mental field Miss Rothery entered the Ontario Government Service, where she served as superintendent of nurses at the Rockwood Hospital, Kingston. As supervisor of nursing for the Ontario Hospitals she organized the nursing service in the new mental hospital at St. Thomas. When this hospital was taken over by the Dominion Government as an Air Training Centre she returned to training school work in connection with the Ontario Hospital at New Toronto.

During the period of administration as supervisor of nursing for mental hospitals Miss Rothery accomplished outstanding work in establishing a closer relationship between general and mental training schools. Affiliations were lengthened and improved in content and teaching. A course for male nurses in the Ontario Hospitals was established and personal attention was given to the arrangement of the curriculum and selection of candidates.

Those who were associated with Miss Rothery can testify to the value of her contribution to nursing during her too brief life, to the keeness of her mind, and her sound preparation for teaching and administration. As a discriminating reader and a fine musician Miss Rothery brought something intangible to her students and they will not soon forget her uncompromising attitude to anything which would bring discredit to the profession. To her graduate staff and students she was at all times their guide, councillor, and friend.

On Duty in South Africa

A letter recently received by Saskatchewan friends of Martha Loken (Saskatoon City Hospital) reveals interesting sidelights on life in South Africa:

The scenery here is really marvellous with tall majestic oaks and pines. From my window I can see Table Mountain and I spent my day off on the beach glorying in the surf-bathing, wind and sun. The military nurses here have khaki uniforms and stripes on their shoulders in place of our pips. They wear white on duty with brown shoes, stockings and hats. We are the first Canadian nurses to be stationed near Capetown and everyone is extremely kind, and we have more invitations than we can find time for.

The actual ward work is done by women who belong to St. John Ambulance or are V.A.D.'s. The patients have all the common complaints, including dysentery and quite a bit of malaria. We are too far from the war zones to get real casualties. In the operating room sterile supplies are kept in drums, each with one kind of article in it—gloves, gowns, towels, sheets, etc. The skin towels and laparotomy sheets are bright green, a sort of silky repp material. The anaesthetic tables are very completely equipped.

Fifty Years Ago

It is almost a complete half-century since that October day in 1892 when, amid congratulations and good wishes, I became the proud possessor of the diploma and medal of the Mack Training School of the St. Catharines General Hospital. Looking back to my period of training I know that, in comparison to the conditions of modern hospital life, we must have had many inconveniences and handicaps, but I think we generally took them for granted and regarded it as simply our duty to use our ingenuity to overcome them and to take just as good care of our patients as if no handicaps existed.

The necessity for this was more likely to be met in a private home than in the hospital and, in our day, pupil nurses were obliged, after the first six months, to go out and nurse cases in private homes. Not necessarily in the city either, but wherever the superintendent deemed it avisable to send us. Calls came from the surrounding district—from Toronto, Peterborough, Lindsay, and as far away as Montreal. These outside cases were regarded as a continuation of our training, and, believe me, they certainly were. The training previously given us had been with a view to fitting us for private work as well as hospital nursing and it is a satisfaction to recall how successful, almost without exception,

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our pupil nurses were. But, I am bound to confess that the pupil nurses themselves sometimes suffered especially from long hours, overwork and lack of sufficient sleep. A second nurse, even in very critical cases, was so rare that, in my time, few of us ever experienced that joy.

As our School had been graduating nurses for years before my time, we did not then think of ourselves as pioneers, but looking back now, I realize that to a certain extent we were. Some of the homes we entered had never previously known a hospital nurse. It was not unusual to find ourselves regarded as curiosities, not to say freaks. That we turned out to be young women of average appearance possessed of average human qualities was a beautiful surprise to the patient's anxious relatives.

Regarding our hospital duty, the hours were long and the work was hard. We led a pretty strenuous life, but the only real hardship that I recollect was my three months period of night duty. One nurse, on duty all alone from seven at night until seven in the morning, in charge of all the wards upstairs and down, with perhaps thirty patients—typhoid, pneumonia, fractures—anything and everything except contagious diseases. All this with the distinct understanding that no patient must be neglected, no bell go unanswered. "Sewing duty" was another *must* of our time, and quite unpopular it was. None of us did enough of it to become skilled makers of hospital gowns, but we all laboured at it more or less faithfully. One girl, I recollect, considered it a very poor reward for her struggles when she was told that her buttonholes looked "just like pig's eyes." Fifty years ago, social affairs were few and far between for the pupil nurses—no movies, no joy-rides, except an occasional one with a young man in a covered buggy, but that was a hilarious relaxation, and I can vouch for the fact that it was very decidedly frowned upon. But a group of lively, congenial girls did not need to depend on outsiders to supply amusement. They found plenty of ways all their own.

ANN E. HUTCHISON
Class of 1892
Mack Training School

McGill School for Graduate Nurses

Owing to circumstances arising out of the war, there is an urgent need of qualified teachers and supervisors in hospitals. The care of patients, and the teaching of students in the clinical fields must be safeguarded. To meet this emergency, the School for Graduate Nurses is offering a four-months course in the second term of the Session 1942-43, to prepare nurses to assume executive, teaching and supervisory responsibilities in the various hospital services. Nurses who apply for this course should have had not less than a year of graduate experience, and, if possible, at least six months in the particular nursing service in which they severally wish to specialize.

The course will be designed to provide a concentrated period of two months of lectures, followed by two months of experience in the particular clinical field which the respective students have selected for specialization. In addition to opportunities for becoming acquainted with the nursing service and the newer therapeutic measures relating to the care of patients, practice will be provided in teaching, supervision and ward management. The teaching hospitals affiliated with McGill University will be used for this purpose.

The cost of the course, including tuition and maintenance, will be approximately from $350 to $400, not including travelling expenses.

Nurses who wish to complete the course leading to a certificate in Teaching and Supervision by returning for another four-months period, within a reasonable time, must meet the requirements for entrance to McGill University.

The course will begin on Wednesday, January 6, 1943. Registration must be complete not later than December 15, 1942. The necessary application forms may be secured from the Secretary, School for Graduate Nurses, 3466 University Street, Montreal, Quebec. Telephone Number: Ma. 9181 — Local 86.

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WANTED

Applications are invited for a full-time **Instructress** January 1, 1943, at the Brandon Hospital for Mental Diseases. Apply to:

Brandon Hospital for Mental Diseases, Box 420, Brandon, Man.

WANTED

Applications are invited for the position of **Class Room Instructress** for a 100-bed Hospital. Apply, giving qualifications, experience, and salary expected, to:

The Superintendent, General Hospital, Dauphin, Manitoba.

WANTED

Applications are invited for the position of **Nursery Supervisor** in the Salvation Army Grace Hospital, Ottawa, Ontario. This is a women's hospital with 66 adult beds and 50 bassinettes. Apply to:

Major Hannah J. Janes, R.N., Superintendent, Grace Hospital, Ottawa, Ont.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Announcement is made of the appointment of *Miss E. A. Electa MacLennan* to the staff of the National Office of the Victorian Order of Nurses for Canada. Miss MacLennan brings to her new position a background of unusual preparation and experience. A graduate of the Royal Victoria Hospital and of the course in teaching at the McGill School for Graduate Nurses, she has a Bachelor of Arts Degree from Dalhousie University and more recently has obtained a Master of Arts Degree in nursing education from Teachers College, Columbia University. Miss MacLennan has had two years' teaching experience in the Vancouver General Hospital and has served in the capacity of staff nurse and supervisor on the Montreal Branch.

Miss Margaret Trueman, B. A., a graduate of the Montreal General Hospital and of the course in public health nursing, McGill School for Graduate Nurses, has been appointed to the Montreal staff.

Miss Eleanor Fraser, B.A., a graduate of the Royal Victoria Hospital, having recently completed the course in public health nursing at McGill School for Graduate Nurses, has been reappointed to the Montreal staff.

Miss Jeanne M. Sterne, a graduate of the General Hospital, Brantford, and of the course in public health nursing, School of Nursing, University of Toronto, has been appointed to the Toronto staff.

Miss Phyllis Morrison, a graduate of the Toronto Western Hospital, has been appointed temporarily to the Toronto staff.

Miss Floris Zulauf, a graduate of St.

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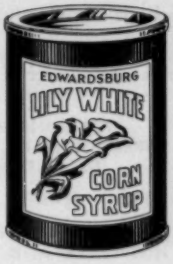

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Michael's Hospital, Toronto, has been appointed temporarily to the York Township staff.

Miss Helene Décary, a graduate of the Sacred Heart Hospital, Cartierville, Montreal, and of the course in public health nursing, University of Montreal, has been appointed to the Lachine staff.

Miss Lucille Bonin has resigned from the Toronto staff to accept a position with the St. Elizabeth Visiting Nurses Association.

Miss Lyle Ferguson and *Miss Betty Thom* have resigned from the Toronto staff to be married.

Miss Betty Burwash has resigned from the Toronto staff to accept a position with the Provincial Department of Health in Cornwall.

Miss Margaret Mansell has resigned from the Toronto staff to serve with the R.C.A.M.C. Nursing Service.

Miss Yvette Notebaert has resigned from the staff in Kirkland Lake.

Miss M. Kaufman, who has been temporarily employed on the Montreal staff, and *Miss Helen Furlong* on the East York staff, have resigned to take the course in public health nursing at McGill School for Graduate Nurses.

Mrs. G. M. Cleaver and *Miss E. Roe* have resigned from the Montreal staff, the latter to take up other work.

Miss Hilda Willis and *Miss Lillian Fryers,* who have been temporarily employed on the Winnipeg staff, have resigned to take the course in public health nursing at McGill School for Graduate Nurses.

Miss Helen Kay, who has been temporarily employed on the Ottawa staff, has resigned to take the course in public health nursing at the School of Nursing, University of Toronto.

Miss Hazel Ingram has resigned from the Winnipeg staff to serve with the R.C.A.M.C. Nursing Service.

Miss Julia Flynn has resigned from the Halifax staff to be married.

Miss Catherine Murray has been trans-

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For information apply to:

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McGill University, Montreal.

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(1) A three-months course is offered in Obstetrical Nursing. (2) A two-months course is offered in Gynecological Nursing. For further information apply to Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital.

(3) A course in operating room technique and management is offered to nurses with graduate experience in operating room work. (4) Courses are also offered in medical nursing; surgical nursing; nursing in diseases of the eye, ear, nose and throat; nursing in urology. For further information apply to Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital.

ferred from the East York staff to take charge of the Huntsville Branch.

Miss Jean Weir has been transferred from the Montreal staff to the Oshawa staff.

Miss Dorothy Paulin has been transferred from the Westbank Branch to take charge of the newly opened branch in Trail, B.C.

Miss Margaret Anderson has been transferred from the Campbellton Branch to be nurse-in-charge of the Amherst Branch.

Miss Christine McArthur has been transferred from the Huntsville Branch to be nurse-in-charge of the Sudbury Branch.

M.L.I.C. Nursing Service

Miss Marie E. Cantin (St. Vincent de Paul Hospital, Sherbrooke, 1926, and public health nursing course, University of Montreal, 1929) head nurse on the Mount Royal staff, Montreal, was recently granted a four-months leave of absence to take a post-graduate course in public health administration and supervision at the McGill School for Graduate Nurses. Miss Cantin was granted a bursary by the Canadian Nurses Association to assist in this course.

Miss Annette Limoges (St. Jean Hospital, P. Q., 1927, and public health nursing course, University of Montreal, 1940), nurse in Jonquiere, P. Q., recently resigned from the Company's service to be married.

Miss Alma Morache (Notre Dame Hospital, Montreal, 1930, and public health nursing course, McGill School for Graduate Nurses, 1938) was recently transferred to take charge of the Company's Service in Niagara Falls. Miss Morache was formerly on the Montreal staff.

Miss Gilberte Violette (Hopital du St. Sacrement, Quebec, 1937) was recently granted leave of absence from the Montreal staff to take an eight-months course in public health nursing at the School of Nursing, University of Montreal. Miss Violette will be given a scholarship by the M.L.I.C. to assist in her course.

Miss Lillian Wark (Toronto General Hospital, 1930, and public health nursing course, University of Toronto, 1933) recently resigned as Metropolitan nurse in Sudbury.

Ontario Public Health Service

Miss Isobel Deeth (Hamilton General Hospital and University of Toronto public health nursing course) has resigned from the nursing staff of the Hamilton Department of Health to accept a position with the Visiting Nursing Association of Hespeler.

Miss Elsie Franks (Toronto General Hospital and University of Toronto public health nursing course) has joined the public health nursing staff at Timmins. She was formerly with the Kirkland Lake Board of Health.

Miss Lillian Lawder (Hospital for Sick Children and University of Toronto public health nursing course) has accepted the position of public health nurse at Fort Frances.

Miss Helen M. Elliott (Hamilton General Hospital and University of Toronto public health nursing course) has accepted the post of public health nurse with the Board of Health at Cochrane.

Mrs. Louise Harding (Montreal General Hospital and University of Toronto public health nursing course) is carrying on the school health service at Long Branch during *Miss Agnes Alexander's* leave of absence. Miss Alexander is enrolled in the public health nursing course at the School of Nursing, University of Toronto.

Mrs. Phyllis Reynolds, née Kitchen (diploma course in nursing and public health, University of Toronto School of Nursing) has joined the staff of the Woodstock Board of Health.

Mrs. Beverly Howard, née Rogers (diploma course in nursing and public health, University of Toronto School of Nursing) has been appointed to the staff of the Board of Education Health Service in Peterborough, where *Miss Jessie Deyell* is on leave of absence for service with the R.C.A.M.C.

Mrs. Mildred Gehman (Brantford General Hospital and University of Toronto public health nursing course) has been appointed to the staff of the Oshawa Board of Health.

Mrs. Dorothy Shapter, née Armstrong (Hamilton General Hospital and University of Western Ontario public health nursing course) has joined the school health service in Chatham.

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REFRESHER COURSE IN INDUSTRIAL NURSING

The School of Nursing, University of Toronto, announces a refresher course in Industrial Nursing for Registered Nurses to be held from November 23 to 27. The general content will include lectures on industrial hygiene emphasizing medical service in industry; contribution of the nurse to the industrial health programme; health service relationships within industry; mental health and morale; control of wound infection; public health nursing: (a) general principles (b) industrial nursing: objectives, scope, and methods. The teaching in Industrial Nursing will be given by Miss Olive Whitlock, Public Health Nursing Consultant, Division Industrial Hygiene, United States Public Health Service. Round tables will be conducted on the industrial nurse in the community health programme; and industrial nursing, comprising opportunities, problems, and techniques. Observation visits, demonstrations, and a question box will also be part of the programme.

All Registered Nurses interested in Industrial Nursing are eligible for enrolment. Registration fee: $8.00.

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HELEN CARRUTHERS, Reg. N.

Miss Lorraine Larsen (St. Michael's Hospital, Toronto, and University of Toronto public health nursing course) of the Owen Sound Board of Health, has been released for army service.

Miss Phyllis Bronson (diploma course in nursing and public health, University of Toronto School of Nursing) has been appointed to the staff of the East York Township Board of Health.

Miss Hilda Pennock of the supervisory staff, Ontario Department of Health, is attending the administration and supervision in public health nursing course, at the McGill School for Graduate Nurses.

NEWS NOTES

MANITOBA

WINNIPEG:

Winnipeg General Hospital:

Winnipeg General Hospital graduates, who have been granted leave of absence from their positions to attend the McGill School for Graduate Nurses under the Bursary Fund granted to the C.N.A., include Misses Helena Reimer (1937), Gertrude Callin (1941), Beryl Seeman (1935), Eileen Willis (1941), Lillian Fryer (1940), and Florence Stratton (1932). Misses Ruth Crichton (1942) and Beth Rice-Jones (1942) will attend the University of Toronto School of Nursing.

Miss Charolette Counsell (1927) has accepted a position as laboratory technician at Shilo Military Hospital.

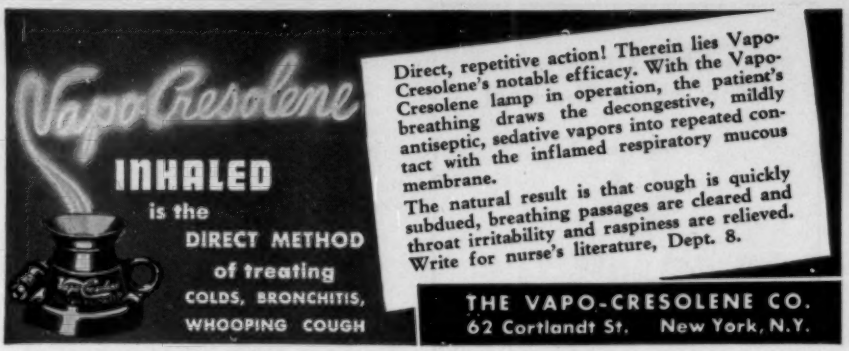
The following marriages have recently taken place: Ethel Wilson (1929) to Edgar English; Irene Yellowlees (1940) to Gordon Inglis.

NOVA SCOTIA

NEW GLASGOW:

Aberdeen Hospital:

The following marriages have recently taken place: Edith Woodworth (A. H., 1936) to George MacDonald; Anne Bartlett (A. H., 1938) to Pte. George Bain Langley; Muriel Lent (St. Martha's Hospital, Antigonish) to Lieut. Douglas MacDonald.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Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, 135 St. Clair Ave. W., Toronto.

ONTARIO

District 4

HAMILTON:

Hamilton General Hospital:

Miss Marjorie Hawes is nursing in a Red Cross outpost in Northern Ontario. Miss Rhea Zinkhann is in Winnipeg training to be a stewardess with Trans-Canada Air Lines. Miss Muriel Suckling is with the B. Greening Wire Co. Miss Mary Watson has joined the nursing staff of the Hamilton Military Hospital. Miss Elizabeth MacDonald is with Dominion Foundries.

The following marriages have recently taken place: Helen Grace McCulloch to Murray Thomas; Lorraine Gamble to Allan Anger; Arystene Simons to Cpl. Earl Weiss.

District 5

Have you made yourself available for any emergency in nursing? Do you need the names of nurses in your area who have registered for such an emergency? If you live in District 5 contact the secretary of the District.

The following outline gives the work carried on by Miss Jean Mitchell for District 5: At the request of the Committee for Civilian Defence, District 5 made a real attempt to register all graduate nurses active and inactive in the District. It was decided that this would require the full-time services of one person for a month. A convener was appointed who was given leave of absence from her own work to undertake this important task. With the co-operation of the press, the C.B.C., the clergy, and hospital staffs, as well as many individuals, a very successful registration was made of approximately 3500 names.

It was our chief aim to make as many contacts as possible so that everyone would know of this registration. Personal visits were made to the newspaper offices and their co-operation was excellent. Permission was granted from officials of the various communions to contact their ministers in order that an announcement might be made from the pulpits. Letters were sent to the ministers throughout the district and they complied with our request. Letters were sent to the hospitals for lists of their staffs. Chapters and alumnae were asked to reach as many of their membership as possible. A number of individual nurses co-operated by contacting their friends and sending in their names. By the response to our efforts it was gratifying to know that nurses are ready and willing to give their services in this time of national emergency. Many registrations were received from nurses outside of our district, some coming from New York, Chicago, and Alaska, as well as from other districts in Ontario.

As a follow-up of this registration letters were sent to all registrants outside of the Toronto area pointing out to them how they can be of service in their own community. In Toronto the names were given to the Committee of Civilian Defence, and letters were sent to all those who were not already registered with the C.D.C.

We feel our efforts were well worthwhile, and it is indeed comforting to know that a file of graduate nurses is now ready in case of an emergency in any community of our District.

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District 7

Kingston:

A Central Registry for nurses has been formed in Kingston with Miss Emma MacLean as registrar. To date there are 82 registered nurses, six doctors, and six practical nurses on its rolls. Miss Madalene Baker recently visited Kingston, and addressed the Board of Directors of the Kingston Central Registry on the advantages of training practical workers. She was greatly pleased with the success of the newly-formed registry.

Kingston General Hospital:

Nursing Sister Lenora Loyst, R.C.A.F. has left for England to take a course in plastic surgery. She is one of the first Canadian Air Force Sisters to leave this country. Nursing Sisters Ann Davis, Fern Baker, Elizabeth De St. Remy, Alice Robertson and Elizabeth Betts have reported for duty in South Africa. The following K.G.H. nurses have enlisted recently with the R.C.A.M.C.: G. Brown, D. Hallt, A. Hewitt, R. Bolster, J. Wallace, P. Atcheson, M. Laturney.

Ontario Hospital:

Miss Marion S. Crawford, superintendent of nurses, has recently enlisted with the R.C.A.M.C. Miss Crawford was also chairman of the Kingston Chapter, District 7, R.N.A.O. Since her enlistment a re-election of officers was held with the results as follows: chairman, Miss E. G. Smith; vice-chairman, Miss A. Ardell; secretary-treasurer, Miss Pearl Gavan. Miss Pearl Gavan is now acting superintendent of nurses at the Ontario Hospital.

The sum of $142 was collected by the nursing staff at the O. H. in aid of the British Nurses Relief Fund.

Hotel Dieu Hospital:

Nursing Sister Margaret Merkley has reported for duty in South Africa. Miss E. Allen and Miss F. O'Connor have enlisted with the R.C.A.M.C. Miss M. B. Sullivan has enlisted with the R.C.A.F.

District 10

Port Arthur:

A regular monthly meeting of District 10 was held recently in the General Hospital when Miss Georgina Hayes was the guest speaker. Miss Hayes, a member of the staff of the General Hospital, told of her work in the American Hospital in Paris prior to the war, of the great amount of work done by the few doctors and nurses available, and of how they were constantly on the move following casualties. After the German occupation of Paris, she was taken prisoner. The story of her escape and of the suc-

ceeding months when she was trying to get out of Europe was extremely interesting.

The annual meeting will be held December 7, at the McKellar General Hospital, Fort William.

The following are attending the School of Nursing, University of Toronto: Miss Dorothy Chedister, of Port Arthur General Hospital, Miss Louise Beeman, of McKellar Hospital, and Miss Mary Proskurniak, of the Fort William Sanatorium staff.

The following marriages have recently taken place: Ruth Johnson (St. Joseph's Hospital, Port Arthur) to Vernon Dicks; Miss Nora Gillespie (Hospital for Sick Children) to Bruce Russell.

QUEBEC

MONTREAL:

Montreal General Hospital:

The "Spitfire" group recently held a rummage sale and netted the sum of $110, to add to their fund. The group, under the leadership of Miss Gertrude Calder, recently held a sale of fancy articles and homemade cooking and cleared about $850, which will go to the British Nurses Relief Fund.

Miss Miriam Smeltzer (1942) has accepted a position at the Alexandra Hospital. Miss Hilda McLeod, Miss Margaret Todd, Miss Olive Stewart, Miss Knowlton, Miss Isabel Johnston, all 1942 graduates, are doing floor duty at the Western Division. Miss Luella Wilbur (1942) has accepted a position at the Royal Victoria Montreal Maternity Hospital. Miss Margaret Harrison (1942) and Miss Gibson (1942) are engaged in floor duty at the central Division. Miss E. G. Perkins (1942) has been taken on the staff of the Central Division as one of the night supervisors replacing Miss Simms who has resigned.

Miss Marjory Tupper (1941) has resigned from the staff of the Central Division and has been accepted as a Nursing Sister with the R.C.A.F. Prior to her leaving, Miss Holt and staff entertained in her honour and presented her with a suitable gift. Miss Marguerite O. Cérat (1934) is now a 2nd Lieutenant with the American Naval Command, 33rd General Hospital, Fort Eustis, Virginia. Miss Edith Simms, Miss Anna Christie, and Miss Katherine Kindle (1940) are taking the course in teaching and supervision at the McGill School for Graduate Nurses. Miss Simms and Miss Christie have been awarded scholarships from the M.G.H., and Miss Kindle from the Alexandra Hospital.

Married: Recently, Miss Muriel V. Halliday (1939) to Mr. Marven C. Chase.

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Royal Victoria Hospital:

Miss Madeleine Flander, of the Children's Memorial Hospital, was the guest speaker at the October meeting of the Alumnae Association, when she gave an interesting talk on the Kenny treatment for poliomyelitis.

Miss Nan Lockhart (1923) and Miss Kathleen King (1924) are on duty with the New York-Cornell Unit. Miss Olive Rand (1921) has joined the Bellevue Hospital Unit.

The following marriages have recently taken place: Elsie Lester (1923) to W. G. Hamilton; Pauline Hall (Pauline McBeath, 1935) to Eric McClafferty; Miriam MacLeod (1942) to R. D. Adams; Olive Bartlett (1941) to Dr. Thomas Mathews.

McGill School for Graduate Nurses:

This year, 52 full-time students have registered at the School, in addition to a number who are taking partial courses. This is the largest class on record in the history of the School — we wish them much success in their studies.

Mrs. George F. Harvey (T. & S., 1942) has resigned from the staff of St. Mary's Hospital, Montreal, and has accepted an appointment as instructor at the Jewish General Hospital, Montreal. Gweneth Woodburn (P.H.N., 1942) has been appointed as nurse to the staff of the Bank of Canada, Ottawa. Christine Anderson (P.H.N., 1942) has joined the Nursing Service of the R.C.-A.M.C. and is stationed at Edmonton. Phyllis M. Bridgette (P.H.N., 1940) has resigned from the staff of the Child Welfare Association, Montreal, and has accepted an appointment as industrial nurse with the Canada Carbide Company, Montreal. Edna M. Hattie (P.H.N., 1940) has resigned from the staff of the Royal Victoria Montreal Maternity Hospital (outpatient clinic) and has joined the Nursing Service of the R.C.-A.M.C. stationed at Halifax.

The following marriages have recently taken place: Nellie Goodman (Teaching, 1935) to Keith T. McLeod; Nora McCoy (P.H.N., 1940) to Mr. Sauter.

SASKATCHEWAN

SASKATOON:

Miss Ruth Farnsworth (Calgary General Hospital, 1940) is taking the post-graduate course in teaching and supervision at the McGill School for Graduate Nurses. Miss Elda Graham (S.C.H., 1939) and Miss Edna Larmour (S.C.H., 1939) are taking supervision courses at the Neurological Institute in Montreal.

Official Directory

International Council of Nurses

Acting Executive Secretary, Miss Calista F. Banwarth, 310 Cedar Street, New Haven Connecticut, U.S.A.

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Nova Scotia: (1) Miss M. Jenkins, Children's Hospital, Halifax; (2) Sister Mary Peter, St. Martha's Hospital, Antigonish; (3) Miss Jean Forbes, 314 Roy Bldg., Halifax; (4) Miss M. Ripley, 46 Dublin St., Halifax.

Ontario: (1) Miss Mildred I. Walker, Institute of Public Health, London; (2) Miss Louise D. Acton, Kingston General Hospital; (3) Miss Winnifred Ashplant, 807 Waterloo St., London; (4) Miss Dorothy Ogilvie, 34 Gilchrist St., Ottawa.

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MANITOBA

Manitoba Association of Registered Nurses

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NEW BRUNSWICK

New Brunswick Association of Registered Nurses

Pres., Rev. Sister Kerr, Hotel-Dieu Hospital, Campbellton; First Vice-Pres., Miss L. Smith; Sec. Vice-Pres., Miss R. Follis; Hon. Sec., Miss M. McMullen: *Conveners of Sections*: *Public Health*, Miss M. Hunter; *General Nursing*, Miss M. Harding; *Hospital & School of Nursing*, Miss M. Myers; *Conveners of Committees*: *Advisory Committee of Schools of Nursing*, Miss A. F. Law; *Legislation*, Miss D. Parsons; *The Canadian Nurse*, Miss N. Wallace; *Reps.* to *National Committees*: *Health Insurance & Nursing Service*, Miss B. L. Gregory; *History of Nursing*, Miss A. Burns; *Eight-Hour Duty*, Miss M. McMullen; *Exchange of Nurses*, Miss M. Myers; *Reps. of Chapters & Districts*: Miss A. J. MacMaster, Moncton; Rev. Sr. Saint Stanislaus, Chatham; Secretary-Registrar, Miss Alma Law, Health Centre, Saint John.

NOVA SCOTIA

Registered Nurses Association of Nova Scotia

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ONTARIO

Registered Nurses Association of Ontario

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Miss C. Livingston; *General Nursing*, Miss F. Nevins; *Pembroke Chapter*, Mrs. B. Kipke; *Cornwall Chapter*, Miss M. McWhinnie; *Rep.* to *The Canadian Nurse*, Miss H. Tanner.

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PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

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QUEBEC

Association of Registered Nurses of the Province of Quebec (Incorporated, 1920)

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Saskatchewan Registered Nurses Association (Incorporated 1917)

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Regina Registered Nurses Association

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Alumnae Associations

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A.A., Edmonton General Hospital, Edmonton

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A.A., Royal Alexandra Hospital, Edmonton

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A.A., University of Alberta Hospital, Edmonton

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A.A., St. Paul's Hospital, Vancouver

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A.A., Vancouver General Hospital, Vancouver

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A.A., St. Joseph's Hospital, Victoria

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MANITOBA

A.A., St. Boniface Hospital, St. Boniface

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A.A., Winnipeg General Hospital, Winnipeg

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NEW BRUNSWICK

A.A., Saint John General Hospital, Saint John

Hon. Pres., Miss E. J. Mitchell; Pres., Miss G. Brown; First Vice-Pres., Mrs. H. L. Ellis; Sec. Vice-Pres., Miss S. Hartley; Sec., Miss F. Congdon, S.J.G.H.; Treas., Miss H. Tracy, S.J.G.H.; Assist. Treas., Miss R. Wilson; *Executive*: Misses M. Murdoch, P. White, B. Bain, Mrs. J. Wilson.

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ONTARIO

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A.A., Brockville General Hospital, Brockville

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A.A., Public General Hospital, Chatham

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A.A., St. Joseph's Hospital, Chatham

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A.A., Cornwall General Hospital, Cornwall

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A.A., Guelph General Hospital, Guelph

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A.A., Hamilton General Hospital, Hamilton

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A.A., St. Joseph's Hospital, Hamilton

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A.A., St. Mary's Hospital, Kitchener

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